



EUSTON PLACE

DENTAL PRACTICE



13 Euston Place, The Parade, Royal Leamington
Spa, CV32 4LJ,

PATIENT INFORMATION

Full Name _____ Date of Birth _____ Male Female
 Address _____ Postcode _____
 Doctor's Name & Address _____
 Occupation _____
 Home Phone _____ Mobile Phone _____ Work Phone _____

Who should we contact in case of emergency?

Name _____
 Relationship to patient _____ Emergency Number _____

MEDICAL HISTORY

Are you allergic to any medications or substances? Please tick box below

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other _____

WOMEN: (Please tick) Pregnant/trying to get pregnant Nursing Taking oral contraceptives Other _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.

***If yes to any of the conditions in the grey box, antibiotics may be required prior to examination/cleaning or treatment.**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Leukaemia | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Murmur* (Presently) | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Heart Surgery* | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Crohns/Ulcerative Colitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Recent Blood Transfusion | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypoglycaemia | <input type="checkbox"/> Frequent Diarrhoea | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Hepatitis A (Infectious) | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Asthma | <input type="checkbox"/> Renal Dialysis) | <input type="checkbox"/> Allergies (Medicine |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Congenital Heart Disorder | | | |

Are you taking any medications? Yes No If yes, please list the medication taken below



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DENTAL HISTORY

DENTAL INFORMATION

What prompted you to seek dental care at this time? _____

Do you have any tooth ache or jaw discomfort or pain at this time? _____

Have you been seeing a dentist regularly for checkups and care? Yes No

If so, how often? _____

When was your last dental check-up? _____

When was your last scaling/cleaning appointment? _____

Are you satisfied with the appearance of your teeth? Yes No

Discuss: _____

Are you having any trouble with chewing or eating your food? Yes No

Do you have any sores or growths in your mouth? Yes No

Are you satisfied with your past dental experiences? Yes No

Do you have any dental questions that have never been answered satisfactorily? Yes No

Do you smoke or chew tobacco? If yes, how much? _____

Do you drink alcohol? Yes No If yes, how many units per week? _____

Do you drink fizzy drinks? Yes No If yes, how many drinks per week? _____

Would you like to discuss any of the following with your dentist: (please tick)

- Gum problems or bad breath Crowns Veneers Bridges
- Implants Tooth whitening Dentures Replacement of missing teeth
- Cosmetic Dentistry Treatment for Snoring Treatment for jaw ache/headaches
- Orthodontics – straightening uneven or crooked teeth

Patient Signature (Parent or Guardian) _____
Date _____

Dentist Initials _____
Date _____

Medical History Checks	
Initials:	Date:
Initials:	Date:
Initials:	Date:
Initials:	Date: