CANAM SMILE MAKEOVER
DENTAL CLINIC

Confidential Medical History Form

You will shortly be going through to see your dentist. Before you do, could you take a few moments to answer the questions on BOTH SIDES of this form. This will help us to tailor our services to your requirements. We will show the form at later visits so that you can tell us whether there have been any changes in your general health. All information will be kept strictly confidential by the people caring for you.

Date:				
Your Full Name:			NHS No:	
Title (Mr, Mrs, Miss)		Date of birth:	Sex:	Male / Female
Home Address:				
				Post Code:
Home Tel:			Mobile Tel:	
Work Tel:			Email Address:	
Best method for contact:			Occupation:	
Medical Doctor's Name:			Med. Doctor's Tel:	
Medical Doctor's Address:				
When did you last receive dental treatment?		Within 6 months□ 6-15 months □15 months-3 years □3-5 years □5+years		
Previous Dentist Details				
			Post Code:	
How did you hear about us?(please tick)	Google	Yelp	Facebook	Recommended
	Walking Past	Instagram	Tik Tok	Street Dental Survey/Event
	Other: (please state)			

Are you?	**YES**	**NO**	**Details**
Attending or receiving treatment from doctor, hospital or clinic?			
Taking or have taken steroids in the last 2 years?			
Carrying a medical warning card?			

Do you suffer from?	**YES**	**NO**	**Details**
Attending or receiving treatment from doctor, hospital or clinic?			
Have fever or eczema or any other allergy?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (you or anyone in your family)?			
Arthritis?			

Women only:	**YES**	**NO**	**Details**
Is there any possibility that you may be pregnant?			
Have you had a baby in the last 12 months?			

Did you as a child or since, have:	**YES**	**NO**	**Details**
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			

Treatment that required you to be in hospital?			
A pacemaker, heart surgery or brain surgery?			
Growth hormone treatment before the mid-1980s?			
Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods?			

Drinking

How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirit or a single glass of wine/aperitif)			

Smoking and Chewing

Do you smoke any tobacco products now (or did you in the past)? How many times per day?			
Please provide any other relevant medical details or medications (prescribed or self-prescribed) that your dentist should know about:			

SMILE CHECK: The purpose of this questionnaire is for you to analyze your own smile so that you can tell us how you feel about the appearance of your mouth or smile. We continually want to help fulfill your individual needs and wishes.

Questions	YES	NO	Details
Are you satisfied with your teeth and their appearance?			
Are you self-conscious about your teeth when you smile?			
Would you like your teeth whiter?			
Do you have any irregularly positioned teeth which you dislike?			
Do you have discolored teeth which embarrass you?			
Do your front teeth have fillings which do not match the color of your teeth?			
Would you like your teeth to be straighter?			
Do you have space between your teeth that you do not like?			

Patient's Signature

Doctor's Signature