THE CLOCKTOWER DENTAL PRACTICE

DR S.THAKERAR BDS (Bristol), MJDF.RCS (England)
and Associates

9 North End Road
Golders Green
London NW11 7RJ

SURNAME (MR, MRS, MISS, MS)

FORENAME(S)

ADDRESS

POSTCODE

TEL WORK NO.
TEL HOME NO.
DATE OF BIRTH

MOB NO.
EMAIL
OCCUPATION

DENTAL HISTORY

- When did you last see a dentist?
- What for and where?
- What are your expectations for dentistry? Pain relief? ☐ Function? ☐ Aesthetic? ☐
- How did you find out about this practice?
- How do you feel about dental treatment? (i.e. enjoyable/relaxed/nervous/v.nervous)
- Is there anything about your smile you would like to change?
- Is there any urgency in the completion of your dental treatment? ☐ Yes ☐ No

MEDICAL HISTORY

PLEASE TICK	YES	NO
Are you currently pregnant?		
Are you currently receiving treatment from a doctor, hospital or clinic?		
Are you currently taking any prescribed medicines (e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)?		
Are you carrying a warning card?		
Do you suffer from allergies to any medicine (e.g. Penicillin), substances (e.g. latex/rubber) or foods?		
Do you suffer from hay fever or eczema?		
Do you suffer from bronchitis, asthma or other chest conditions?		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?		
Do you suffer from heart problems, angina, blood pressure problems or stroke?		

Are you diabetic (or is anyone in your family?)		
Do you suffer from arthritis?		
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?		
Do you suffer from any infections/diseases (including HIV and Hepatitis)?		
Do you suffer from Osteoporosis and taken medicine for this?		
Have you ever had liver disease (e.g jaundice, hepatitis) or kidney disease?		
Have you ever had any serious illness/illnesses?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you ever had a joint replacement or other implants?		
Have you ever had treatment that required you to be in hospital?		
Have you ever had heart surgery?		
Do you regularly drink more than 14 units of alcohol per week?		
Do you regularly drink more than 21 units of alcohol per week?		
Do you smoke any tobacco products now (or did you in the past)?		
Do you chew tobacco, paan, use gutkha or supari now (or did you in the past)?		
Is there any other information which your dentist might need to know about, such as self prescribed medicines (e.g aspirin)?		

Doctor's Name: _____ Postcode: _____

Practice Name: _____ Practice Number: _____

Practice Address: _____

_____

SIGN _____ DATE

PLEASE PRINT AND FILL THIS FORM. BRING IT ALONG WITH A LIST OF ALL YOUR MEDICATIONS.

Date: Changes in Medical History:

_____ _____

_____

_____ _____

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