DENTISTRY @ MARKETHILL

FAMILY, ORTHODONTIC AND COSMETIC CARE

Patient Name: ______________________

Date of Birth: ______________________

ENJOY YOUR SMILE!

MEDICAL & DENTAL HISTORY

82 MAIN STREET MARKETHILL CO. ARMAGH BT60 1PL
T: 028 3755 2000 ROI T: 048 3755 2000 E: info@dentistrymarkethill.com
W: www.dentistrymarkethill.com

confidential medical history

To offer the best and most appropriate dental care please provide us with as much detail as possible about your medical history.

Please complete all questions.

Title ________ Full Name ____________________

Date of Birth ____________________

Address ____________________

____

Postcode ____________________ Home No ____________________

Mobile No ____________________ Work No ____________________

Email ____________________

Occupation ____________________

Name and address of your doctor ____________________

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____

How did you hear about the practice? ☐ Friend/Family ☐ Social Media ☐ Website

If other please can you tell us

____

Are you:	Circle	Details
Receiving treatment from your doctor or hospital?	Yes/No	
Pregnant or likely to be so?	Yes/No	
Taking any medication?	Yes/No	

(e.g. tablets, ointments, inhalers - including contraceptives and hormore replacement therapy)

Please list medication below:

____

____

____

____

____

____

____

Have you:	YES	NO	Details
any allergies (eg penicillin, substances (eg latex, rubber) or foods?	☐	☐	
heart problems, heart surgery, angina, blood pressure problems, or stroke?	☐	☐	
had rheumatic fever or chorea?	☐	☐	
had liver disease (eg jaundice, hepatitis) or kidney disease?	☐	☐	
asthma, bronchitis, or other chest conditions?	☐	☐	
ever had a blood refused from the Blood Transfusion Service?	☐	☐	
ever had a bad reaction to general or local anaesthetic?	☐	☐	
any close relative (parent, sibling, child, grandparent or grandchild) with Creautzfeldt Jakob disease?	☐	☐	
arthritis?			
a joint replacement or other implant?			
any other serious illness?			

Do you:	YES	NO	Details
experience fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
carrying a medical warning card?	☐	☐	
bruise or bleed excessively following injury, tooth extraction or surgery?	☐	☐	
smoke any tobacco products now (or did you in the past)?	☐	☐	
regularly drink more than 21 units of alcohol per week?	☐	☐	
suffer from infectious diseases (including HIV and hepatitis)?	☐	☐	
Are you diabetic (or is anyone in your family)?	☐	☐	
Is there any other information which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)?	☐	☐	
snore?	☐	☐	
feel tired during the day?	☐	☐	

Signature ____________________ Date ____________

dental menu

Let us help you to improve your mouth and smile

Please tick the relevant boxes to help us know your current dental concerns

YES	NO	
☐	☐	Would you like your teeth to look whiter or brighter?
☐	☐	Are your teeth sensitive to hot & cold?
☐	☐	Have you any teeth you think are unsightly, misshapen or out of line?
☐	☐	Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?
☐	☐	Do you have any old or stained fillings that show when you smile?
☐	☐	Do you have any silver fillings that you prefer were tooth coloured?
☐	☐	Do you have any missing teeth that you would like replaced to improve your smile and bite?
☐	☐	Do you have an old, worn denture, or an NHS denture that looks false and feels false?
☐	☐	Are your teeth stained or your gums red and swollen?
☐	☐	Do your gums bleed when brushing?
☐	☐	Do you get a bad taste in your mouth or around some teeth?
☐	☐	Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?

Date ________	Date ________	Date ________
Signature ________	Signature ________	Signature ________
Date ________	Date ________	Date ________
Signature ________	Signature ________	Signature ________
Date ________	Date ________	Date ________
Signature ________	Signature ________	Signature ________
Date ________	Date ________	Date ________
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