carnegie dental clinic

Name:. . . . . .

Medical History Form - N.B. If you answer yes to any question please provide details below

Question	Answer (Yes/No)
Are you currently receiving any medical treatment?	
Are you currently taking any prescribed medication (including HRT/contraceptives)	
Do you carry a medical warning card?	
Are you allergic to any medicines/ substances /foods?	
Do you suffer from hayfever or eczema?	
Do you have any chest conditions eg asthma/ bronchitis?	
Do you suffer from fainting/ blackouts/ panic attacks/ epilepsy?	
Do you suffer from cold sores?	
Are you diabetic (or is anyone in your family)?	
Do you suffer from arthritis or osteoporosis?	
Do you bleed excessively after a tooth extraction or bruise easily?	
Have you ever had blood refused by the Blood Transfusion Service?	
Have you ever reacted badly to a local or general anaesthetic?	
Do you suffer from any heart problems eg angina/ blood pressure/stroke?	
Have you had heart or brain surgery?	
Have you had liver disease or kidney disease?	
Do you suffer from any infectious diseases eg HIV/ hepatitis?	
Did you receive growth hormone treatment before 1985?	
Do any of your close relatives suffer from Creutzfeldt Jakob disease?	
How many units of alcohol do you drink per week?	
Do you/ did you smoke tobacco ?	
Do you/ did you chew tobacco, pan, use gutkha or supari ?	
Do you take any self prescribed medications (eg aspirin)	
Is there a history of gum disease in your family?	
On how many occasions do you consume sugary foods or drinks each day?	
Do you take bisphosphonate medication as tablets/ injection?	
Are you happy with your smile? What would you change?	
What is your occupation?	
How long ago was your last dental examination?	
What made you choose Carnegie Dental Clinic / how did you hear about us?	

Home phone no: . . . . . Work phone no: . . . . . Mobile no: . . . . . .

Doctor's Details: . . . . . .

Please sign and date: . . . . . .

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Name:. . . . . .

Carnegie Clinic Smile Assessment - Do any of the following statements apply to you?

Please tick any statement that you think might apply to you

Tick?	Question
	I am self conscious about my teeth when I smile
	I would like my teeth to be whiter and brighter
	I have old dental work that is noticeable and spoils my smile
	When I smile there are gaps or spaces between my teeth that concern me
	I have dark or discolored teeth that I don't like
	My gums bleed when I brush my teeth
	I have bad breath
	My teeth are sensitive
	I have a denture that looks/feels false
	I have wrinkles and would like to discuss wrinkle reducing treatments

On a scale of 1–10 (poor–excellent) how would you rate your smile?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Email Consent Form

At Carnegie Dental Clinic we may send you appointment reminders via email and/or text messaging. If you would like us to send you appointment reminders please fill in all the details below.

Patient name . . . . . .

Email address. . . . . .

Mobile phone number . . . . . .

I would like reminders for myself (and my family) sent by email: ☐ Y ☐ N

We may also occasionally send you dentistry updates, newsletters or offers relating to the Carnegie Dental Clinic. We will not share your email address with other companies. If you would like to opt out of this service please let us know.

Patient Signature: . . . . . .Date: . . . . . .