GUINEA COURT
CONFIDENTIAL MEDICAL HISTORY

PLEASE COMPLETE IN BLOCK CAPITALS

Surname..**Forename(s)**..**Title**..
Address ....**Tel: Home:**…………………………………………………..
....**Mobile:**……………………………………………….
....**Work:**...
Post Code……………………………   **Email:**…………………………………………………..
Occupation...**Date of Birth**......./......./.............
Doctors Name, address & Telephone No..
....

PLEASE GIVE DETAILS

Do you have private medical insurance? - - - - Yes □ No □.......................................
Do you have dental insurance? - - - - Yes □ No □ …………………………..

HAVE YOU EVER:

Been in hospital for a serious illness? - - - - Yes □ No □....................................
Had rheumatic fever / endocarditis? - - - - - Yes □ No □....................................
Had any heart problems, e.g, angina, murmurs,
blood pressure, stroke, heart attack? - - - - - Yes □ No □.....................................
Had chest problems,e.g, bronchitis? - - - - - Yes □ No □.....................................
Had jaundice, liver disease or hepatitis? - - - - Yes □ No □.....................................
Had a joint replacement or other implant? - - - - Yes □ No □.....................................
Had a bad reaction to an anaesthetic? - - - - Yes □ No □.....................................
Been turned down as a blood donor? - - - - Yes □ No □.....................................

ARE YOU:

Attending or receiving treatment from a doctor, hospital or clinic: - Yes □ No □.....................................
Taking any medicines or tablets of any type? - - - Yes □ No □.....................................
Have you/are you taking any Bisphosphonate medication e.g . for osteoporosis
(such as: Didronel, Fosamax or Actonel)? - - - Yes □ No □.......................................
Allergic to any medicines or materials in particular penicillin? - Yes □ No □.......................................
Taking or taken steroids in the past year - - - - Yes □ No □.......................................
A diabetic? - - - - - - - - Yes □ No □.......................................
Prone to bruise easily? - - - - - - Yes □ No □.......................................
Prone to fainting attacks, giddiness, blackouts or epilepsy? - Yes □ No □.......................................

Pregnant or had a baby in the past year? (Please state expected or actual date of birth) ..../........../..........

To help us gain an insight into your dental needs and desires, please complete the following questionnaire.

Are you happy with all aspects of your smile? - - - - - -Yes □ No □
Do your gums bleed on brushing and / or flossing? - - - - -Yes □ No □
Do you have loose teeth (natural or false)? - - - - - -Yes □ No □
Do you have any pain or sensitivity? - - - - - - - -Yes □ No □
Are you aware of grinding or clenching your teeth and / or suffer from headaches? -Yes □ No □
Do you or your partner snore? - - - - - - - -Yes □ No □
Do your teeth look as bright as you would like? - - - - - -Yes □ No □
Are you concerned about poorly aligned or misshapen teeth? - - - -Yes □ No □
Do you have any missing teeth that you would like to have replaced? - - -Yes □ No □

Signature...................................... **Date**........../.........../ 20.............