

# The Witterings Dental Practice Ltd

Ingol Cottage , Cakeham Road, East Wittering ,PO20 8BP

Tel: 01243 672362 Fax: 01243 671683

## MEDICAL HISTORY FORM

Title: First Name(s):

Last Name:

Address:

Date of Birth:

NHS No (if known):

Telephone Home:

Mobile:

Work:

Occupation:

Personal Email address:

Doctor's Name:

Doctor's Surgery/Address:

Doctor's Telephone:

Emergency Contact Name & Telephone Number:.....

Please tick any conditions that apply to you now or you have suffered from in the past.

Heart:

Rheumatic fever

High Blood Pressure

Heart Surgery

Pacemaker Fitted

Heart Murmur

Angina

Thrombosis

Other Heart Conditions:

Chest:

Bronchitis

Emphysema

Pneumonia

Chest Surgery

Smoker

Cystic Fibrosis

Pleurisy

Other Chest Conditions:

Blood:

Bleeding

Hepatitis B

HIV

Anaemia

Blood Test

Sickle Cell

Haemophilia

Other Blood Conditions:

Other:

Serious Childhood Illness

Diabetes

Liver Disease

Kidney Disease

Epilepsy

Cancer

G.A Experience

Hiatus Hernia

Other Conditions:

Allergies:

Penicillin

Hay Fever

Anti Tetanus Serum

Eczema

Aspirin

Asthmatic

Latex Allergy

Other Allergic Conditions:

Warnings:

No Local Anaesthetic

Antibiotic Cover

Do Not Recline

Pregnant

Warning Card

Artificial Joint

Special Precautions

Medication: (Please list below, any prescribed or non prescribed medication that you are taking)

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.....

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.....

.....

Patient / Guardian / Carer's Signature:.....Date:.....

*(Please delete as appropriate)*

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## Oral Health

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**Title: First Name(s):**

**Last Name:**

**Address:**

**Date of Birth:**

**Telephone:**

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Please tell us about your smile. Tick any statements below that apply to you.

### Areas of concern

- I have pain or sensitivity in my teeth or gums.
- My gums appear red and swollen, or bleed when brushed.
- I am worried about bad breath or a bad taste in my mouth.
- I have dry mouth.
- I find it difficult to chew.
- I have clicking or pain in my jaw.

### Appearance

- I am dissatisfied with the appearance of my teeth.
- I feel self-conscious when I smile.
- I wish some of my teeth were shaped differently.
- I have irregularly positioned teeth that I dislike.
- I have chips or gaps in my teeth that worry me.
- I have discoloured teeth that are noticeable.
- I wish my fillings matched the colour of my teeth.

### Information

- I would like to know more about adult braces.
  - I would like to find out more about teeth whitening.
  - I would like to find out more about snore guards / night guards
  - I would be interested in advise on a better toothbrush or brushing techniques.
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**Patient / Guardian / Carer's Signature:.....Date:.....**

*(Please delete as appropriate)*