The Ivy Dental Practice Confidential Medical & Social History Form

For or your safety; it is important that your dentist is aware of your current and past medical history.
The information is bound by data protection laws and is for our information only.

Title: Mr/Miss/Mrs/Ms/Mx/Master/Dr (Please Circle) **Name:**____

Date Of Birth:_________________ **Email:**________________________ **Telephone:**_______________________________

Address____**Postcode**__________________________

Which of the following best describes how you think of yourself (completion for under 16 years optional) :

☐ Man (including trans men) ☐ Woman (including trans women) ☐ Non-Binary ☐ In another way (please state): ____________________

Is your gender the same as you were assigned at birth? ☐ Yes ☐ No

Which of the following best describes how you think of yourself: ☐ Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual

☐ In another way (please state): _______________________________

Medical History

Please indicate if you suffer from any of these conditions:

- € ARE YOU CURRENTLY RECEIVING TREATMENT FROM A DOCTOR, HOSPITAL OR CLINIC?
- € ALLERGIES TO ANY MEDICINES, SUBSTANCES OR FOODS or CARRY A MEDICAL WARNING CARD
- € PREGNANT OR POSSIBLY PREGNANT
- € ASTHMA, BRONCHITIS OR OTHER CHEST COMPLAINT
- € BONE OR JOINT DISEASE
- € DIABETES
- € EATING DISORDER
- € FAINTING, GIDDINES, BLACKOUTS OR EPILEPSY
- € GASTRO-OSEOPHAGEAL OR ACID REFLUX
- € HEART PROBLEMS, ANGINA, BLOOD PRESSURE PROBLEMS OR STROKE
- € INFECTIOUS DISEASES (INCLUDING HIV AND HEPATITIS)
- € LIVER (JAUNDICE OR HEPATITIS) OR KIDNEY DISEASE
- € ANY OTHER CONDITION NOT LISTED HERE
- € TAKING ANY PRESCRIBED / NON-PRESCRIBED MEDICATION LIST BELOW:

List medication:

Please give the name of your GP and/or Clinic below:

Practice name:

Address:

Social History

SECTION A – to be completed for all patients

Do you use a fluoride toothpaste?

- € Yes
- € No

As far as you are aware do you clench or grind your teeth?

- € Yes
- € No

Which of the following do you have each day? (please tick all that apply)

- € Medicines containing sugar
- € Sugary carbonated (fizzy) drinks
- € Diet carbonated (fizzy) drinks
- € Sugary snacks between meals
- € Sugar in hot drinks
- € Sugary snack or drink before bedtime

SECTION B – to be completed for child (under 18 years of age)

Have you had any tooth decay before?

- € Yes
- € No

Do you have any brothers/ sisters who have had tooth decay in the last two years?

- € Yes
- € No

Do you wear a fixed or removable brace or retainer?

- € Yes
- € No

SECTION C – to be completed for adult patients (18 and over)

Have you had any tooth decay in the last two years?

- € Yes
- € No

Do you smoke cigarettes or use any form of tobacco (including smokeless tobacco products)?

- € Yes
- € No

If you answered yes, approximately how many, or how often per day?________________________

Do you drink alcohol?

- € Yes
- € No

If you answered yes, approximately how units per week do you drink?________________________

* In the UK, one alcohol unit is measured as 10ml or 8g of pure alcohol. This equals one 25ml single whisky (ABV 40%), or a third of a pint of beer.

ANY OTHER INFORMATION:		
Signed Date	☐	(If signing for someone else, relationship to patient) ❑ Parent/guardian ❑ Partner ❑ Other _________________

Checked By **Dentist to sign**:……………………………… (Please double check the e mail, mobile number and medical practice)