



Clinic name

Address · Phone · Licence no.

Dental and medical history questionnaire

Please fill this in before your first visit; we will check it with you at every visit. Your answers help us treat you safely.

Clinic use: file no. _____ Date _____

About you

Full name _____ Date of birth _____
Mobile _____ Email _____
City and district _____ Occupation _____
Emergency contact and phone _____ Your doctor and phone _____
Sex ☐ Male ☐ Female

Why you are here today

- | | | |
|--|---|--|
| ☐ Check-up | ☐ Pain | ☐ Broken tooth or filling |
| ☐ Cleaning | ☐ Bleeding gums | ☐ Whitening or cosmetic |
| ☐ Replace a missing tooth | ☐ Straighten teeth | ☐ Other: |

Tell us in your own words _____

Your health: do you have, or have you had...

Question	Yes	No	Details
A heart problem, angina or a heart attack	☐	☐	
An artificial heart valve or past endocarditis	☐	☐	
High blood pressure	☐	☐	
Bleeding that is slow to stop, or bruising easily	☐	☐	
A blood-thinning medicine	☐	☐	
Diabetes	☐	☐	
Asthma or a chest condition	☐	☐	
Epilepsy or seizures	☐	☐	
Liver or kidney disease	☐	☐	
Hepatitis or another blood-borne infection	☐	☐	
Cancer treatment, or radiotherapy to the head or neck	☐	☐	
Tablets or injections for osteoporosis (such as bisphosphonates)	☐	☐	
A joint replacement	☐	☐	
Steroids or medicines that lower immunity	☐	☐	
A hospital stay or operation in the last two years	☐	☐	
Pregnant or breastfeeding (women)	☐	☐	

Full name Date

Medicines

Everything you take now, including herbal remedies and supplements

Allergies: are you allergic to...

Question	Yes	No	Details
Penicillin or another antibiotic	☐	☐	
Latex (rubber gloves)	☐	☐	
Local anaesthetic	☐	☐	
Painkillers	☐	☐	
Anything else	☐	☐	

Tobacco ☐ Never ☐ Used to ☐ Cigarettes ☐ Shisha ☐ Vape ☐ Chewing tobacco

Your teeth

Last visit to a dentist What it was for

Question	Yes	No	Question	Yes	No
A problem with a dental injection before	☐	☐	Heavy bleeding after an extraction	☐	☐
Gums that bleed when you brush	☐	☐	Sensitivity to cold or sweet	☐	☐
Jaw pain or clicking	☐	☐	Grinding or clenching	☐	☐
A dry mouth	☐	☐	A bad experience at the dentist before	☐	☐

How anxious do you feel about dental treatment? Tick one number.

Relaxed	0	1	2	3	4	5	6	7	8	9	10	Very anxious
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

You brush ☐ Once a day ☐ Twice or more ☐ Now and then

You clean between teeth ☐ Daily ☐ Sometimes ☐ No

Declaration and consent

The information above is correct to the best of my knowledge, and I will tell the clinic about any change in my health or medicines. I agree to the examination and the radiographs needed for a diagnosis; any treatment after that will be explained to me and agreed first.

Your privacy: this form is kept in your file at the clinic, seen only by the people treating you, and used only for your care.

.....
Patient or guardian signature

.....
Relationship, if guardian

.....
Date

Clinic use: reviews

Date	What changed	Patient initials	Reviewed by

In Dentolize this document lives on the patient file: dentolize.com