

**Dr. David J J Cowan**

**Holistic Dentistry**

*Setting the Highest Standards in Dental Care*

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**CONFIDENTIAL MEDICAL HISTORY**

Surname..... Mr. Mrs. Miss Ms. Dr.

First name(s) .....

Date of birth .....

Address.....  
.....

Postcode .....

Tel No. home: .....

Tel No. work: .....

mobile: .....

Fax: .....

e-mail:  
.....

Occupation: .....

Medical Practitioner's address: .....

In case any previous records are required, please supply name and address of last dental practitioner:

.....  
.....

In order that your dentist can give you the most appropriate treatment it is important to know whether you are currently receiving any medical treatment or taking any pills, medicines or drugs. It will also help if your dentist has details of any past illnesses and it is for this reason that you are asked to answer the attached questions.

*Kindly turn to page 2*

**2.**

1. Are you receiving treatment from your doctor, hospital or clinic and please specify type?

.....  
.....

2. Please list all medications and dosages:

(a)..... (b)..... (c) .....

(d)..... (e)..... (f).....

3. Do you have now or have had in the past, any problems with your heart, blood pressure, circulation .....

Have you had:

HEART ATTACK .....

STROKE .....

SHUNT SURGERY .....

RHEUMATIC FEVER .....

HEART VALVE DEFECT REQUIRING SURGERY .....

CORONARY BYPASS .....

ANGIOPLASTY .....

ANGINA .....

JOINT REPLACEMENT .....

4. Do you suffer from sudden fainting or giddiness?.....

5. Do you have chest trouble?.....

6. Have you had JAUNDICE, HEPATITIS, other liver or kidney disease?.....

7. Have you had a general anaesthetic and suffered any side effects or after-effects of a serious nature?.....

8. Have you had abdominal bleeding after extractions, surgery or injury at any time in your life?.....

9. Do you suffer from any allergies including abnormal reactions to local anaesthetics?.....

10. Are you allergic to penicillin or any medicine, food or substance?.....

11. Are you an expectant mother? .....

12. Please state which childhood illnesses you have had:

.....  
.....

Is there anything not so far mentioned, which you think the dentist needs to know?

.....

*kindly turn to page 3*

*Kindly turn to page 2*

**3.**

**Nutrition Section**

Please give a brief description of the types of food and drink consumed in a typical day.

Breakfast.....

Lunch.....

Snacks.....

Dinner.....

If you are taking vitamin/mineral or other nutrition supplements please state brand and dose.

1.....

2.....

3.....

4.....

**Dental Section**

Do your gums bleed at any time, or have you suffered with gum problems in the past and please indicate whether you have had treatment or not? .....

.....

Do you grind your teeth during the day/night or both? .....

Do you wake up with aching/painful jaw muscles? .....

Do you experience any pain in your jaw joints on opening or closing your mouth?

.....

Have you had your wisdom teeth removed? .....

Have you had orthodontic treatment in the past? .....

If you wish to elaborate on any point please do so here .....

.....

I wish to have a consultation at Dr David Cowan's private dental practice and have completed the relevant sections as required.

Signature..... Date .....