

**PERSONAL DETAILS:**

Full name and title.....

Address.....

.....Post Code.....

Home Tel. No.....Work No.....

Mobile No..... Email address.....

Occupation.....

**DENTAL HISTORY:**

[1] Do you go to the dentist regularly?

.....

[2] Is there a particular reason for your visit today?

.....

[3] Where was you last practice?

.....

[4] How often did you attend for a routine examination and hygienist appointment?

Exam: ..... Hygienist: .....

[5] How long ago was your last visit?

.....

[6] Have you had a lot of dental treatment in the past?

.....

[7] Are you in any pain or discomfort at the moment?

.....

[8] Are you happy with your smile?

.....

[9] Would you like to know treatment options to improve your smile?

.....

[10] Please mention any other questions or concerns below:

.....

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Years

Doctors Name, Surgery and Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<u>Please indicate below any conditions that apply:</u>	<b>YES</b>	<b>NO</b>	<b>DETAILS</b>
1. Receiving treatment from a doctor?	___	___	
2. Taking any medicines? (list them under DETAILS)	___	___	
3. Carrying a warning card?	___	___	
4. Pregnant?	___	___	
5. Allergies to medicine/ substances?	___	___	
6. Hayfever or eczema?	___	___	
7. Asthma, Bronchitis or chest condition?	___	___	
8. Fainting, blackouts, epilepsy?	___	___	
9. Heart problems: angina, blood pressure problems, or stroke?	___	___	
10. Diabetes?	___	___	
11. Bone or joint disease?	___	___	
12. Excessive bleeding following injury or tooth extraction?	___	___	
13. Rheumatic fever or Chorea?	___	___	
14. Liver disease or kidney disease?	___	___	
15. Any other serious illness or infectious disease?	___	___	
16. Blood refused by the transfusion service?	___	___	
17. A bad reaction to a general / local anaesthetic?	___	___	
18. Joint replacements or implants?	___	___	
19. Treatment that required hospital admission?	___	___	
20. Have you ever had Heart Surgery?	___	___	
21. Do you smoke now or previously?	<b>YES</b>	<b>NO</b>	<b>PAST</b> Number per day? _____
22. Do you chew tobacco now or previously	<b>YES</b>	<b>NO</b>	<b>PAST</b>
23. How many units of alcohol do you drink per week?	_____		
24. Have you been prescribed steroids in the last 3 years?	<b>YES</b>	<b>NO</b>	
25. Have you EVER been prescribed bisphosphonates?	<b>YES</b>	<b>NO</b>	
26. Do you have a pacemaker?	<b>YES</b>	<b>NO</b>	

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*(If you have many prescriptions please bring copy of your repeat prescription)*