The Dental Surgery

CORN EXCHANGE

Medical and Dental History Questionnaire

Title ________ First Name ______________________________ Surname ____________________

Preferred Name ______________________________ Occupation ____________________

Address ______________________________ Postcode ____________________

Work Telephone Number ______________________________ Date of Birth (dd/mm/yyyy)

dd / mm / yyyy

Home Telephone Number ______________________________

Mobile Number ______________________________

Email Address ______________________________

Next of kin / in Case of Emergency (Name & Tel.) ______________________________

Relationship to this person ______________________________ Is this person a patient? ☐ Yes ☐ No

We send your dental health reminders and confirmations by text and email.

When did you last visit your dentist? ____________________ Hygienist? ____________________

How did you hear about us?

☐ Personal recommendation (word of mouth)
If it was a personal recommendation please tell us who, we would like to say thank you: ____________________

☐ Internet (Google Search) ☐ Advertisement

☐ Social Media ☐ Other ____________________

To help us provide the best treatment for you, please indicate below which treatments interest you.

☐ Regular routine dental checks and maintaining good dental health

☐ Clean teeth, fresh breath

☐ Cosmetic treatment, improving the look of your smile

☐ Teeth whitening

☐ Straightening teeth, orthodontic treatment

☐ Dental implants

☐ Treatment of pain

Do you have any concerns that you would like the dentist to be aware of?

Would you like to subscribe to our newsletter in which we share helpful news relating to these issues?
☐ Yes ☐ No

We have a team of hygienists here at our surgery. Gingival (gum) health has an impact on general and dental health so you may be referred to a member of the hygiene team by your dentist.
Do you suffer from, or are you concerned about, any of the following:

☐ Bleeding gums
☐ Difficulty flossing
☐ Bad breath or bad taste in your mouth
☐ Teeth sensitivity to hot, cold, sugar or pressure
☐ Other concerns ____________________

Please complete what you can below. This will form the basis for discussion with your dentist and enable us to take the appropriate steps to safeguard your health. Your answers are for our records only and will be considered CONFIDENTIAL.

Are you	Yes	No	Details
Attending or receiving treatment from a Doctor, Hospital or Specialist?			
Taking any medication (including pills, creams, inhalers, etc)?			
Taking or have you taken steroids in the last two years?			
Allergic to any medicines, food or materials?			
Pregnant?			
Do you have HIV?			
Have you	**Yes**	**No**	**Details**
Had rheumatic fever or chorea (St Vitus Dance)?			
Had jaundice, liver, kidney disease, hepatitis?			
Any heart problems (murmur, angina, blood pressure, heart attack, etc)?			
Had any blood test or inoculations?			
Ever had your blood refused by the Blood Transfusion Service?			
Ever had a bad reaction to a general or local anaesthetic?			
Ever had a bad reaction to Penicillin or Chlorhexidine?			
Do you	**Yes**	**No**	**Details**
Have arthritis?			
Have a Pacemaker or have you had a form of heart surgery?			
Suffer from hay fever, eczema or any other allergy?			
Suffer from bronchitis, asthma or other chest conditions?			
Have fainting attacks, giddiness, blackouts, epilepsy?			
Have diabetes, or does anyone in your family?			
Bruise easily, or do you or your family have excessive bleeding problems?			
Get cold sores?			
Carry a warning card?			
Do you smoke? If yes, how many a day?			
Do you play any contact sport (hockey/rugby)?			
Approximate units of alcohol consumed per week?			

Are there any other aspects concerning your health that you think the dentist should know about?

Doctor's Name and Address ____________________

Telephone ____________________

Patient's/Guardian signature ____________________ **Date** ____________________

Thank you for taking the time to provide us with these details. We look forward to providing you with quality dental care.
Our cancellation policy is that we require 24 hours' notice. Failure to do so may result in a late cancellation fee. We kindly ask that you give us as much notice as possible.