

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)

Home Telephone Number _____

dd / mm / yyyy
[] / [] / []

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

Gingival (gum) health has an impact on general and dental health so you may be referred to a member of the hygiene team or our periodontist by your dentist.

Do you, or any member of your family, have a history of gum disease: Yes No

Do you suffer from, or are you concerned about, any of the following:

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

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.**