BALLYCLARE DENTAL PRACTICE

SMILE

Medical & Dental History

Patient Name: ______________________________

Date of Birth: ______________________________

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Confidential Medical & Dental History

To offer the best and most appropriate dental care we ask that you provide us with as much detail as possible about your medical & dental history. Thank you.

Please complete all questions & tick the relevant boxes.

Title ______ Full Name ______

Date of Birth ______

Address ______

______

Postcode ______ Home No ______

Mobile No ______ Work No ______

Email ______

Occupation ______

Name and address of your doctor ______

______

______

How did you hear about the practice? ☐ Friend/Family ☐ Yellow Pages ☐ Internet/Website

If other please can you tell us

______

	Circle	Details
Are you currently pregnant?	Yes/No	
Are you currently receiving treatment from a doctor, hospital or clinic?	Yes/No	
Taking any prescribed medicines?	Yes/No	

(e.g. tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)

If so which?

______

______

______

______

______

	Circle	Details
Are you currently carrying a medical warning card?	Yes/No	
Do you suffer from allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?	Yes/No	
Do you suffer from hayfever or eczema?	Yes/No	
Do you suffer from bronchitis, asthma or other chest conditions?	Yes/No	
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	Yes/No	
Do you suffer from heart problems (including heart murmur), angina, blood pressure or stroke?	Yes/No	
Are you diabetic (or is anyone in your family)?	Yes/No	
Do you suffer from arthritis?	Yes/No	
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?	Yes/No	
Do you suffer from any infectious diseases (including HIV and Hepatitis)?	Yes/No	
Have you ever had rheumatic fever or chorea?	Yes/No	
Have you ever had liver disease (eg jaundice, hepatitis) or kidney disease?	Yes/No	
Have you ever had any other serious illness?	Yes/No	
Have you ever had blood refused by the Blood Transfusion Service?	Yes/No	
Have you ever had a bad reaction to general or local anaesthetic?	Yes/No	
Have you ever had a joint replacement or other implant?	Yes/No	
Have you ever had treatment that required you to be in hospital?	Yes/No	
Have you ever had heart surgery?	Yes/No	
Have you ever had brain surgery?	Yes/No	
Did you receive growth hormone treatment before the mid 1980's?	Yes/No	
Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob disease?	Yes/No	
Do you regularly drink more than 14 units of alcohol per week?	Yes/No	
Do you smoke any tobacco products now (or did you in the past)?	Yes/No	
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?	Yes/No	

Is there any other information which your dentist might need to know about such as self-prescribed medicines (eg aspirin)?

Signature ______ Date ______

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Smile Check

Let us help you to improve your mouth and smile

Please tick the relevant boxes to help us know your current dental concerns

YES	NO	
☐	☐	Are you perfectly happy with your smile?
☐	☐	Do you think your smile could be better?
☐	☐	Would you like your teeth to look whiter or brighter?
☐	☐	Are your teeth sensitive?
☐	☐	Have you any teeth you think are unsightly, mis-shapen or out of line?
☐	☐	Do you have any old crowns or bridges that now do not match your other teeth or have dark lines at the gums?
☐	☐	Do you have any old stained fillings that show when you smile?
☐	☐	Do you have mercury fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?
☐	☐	Do you suffer from headaches, jaw ache or does your jaw click?
☐	☐	Do you have worn teeth?
☐	☐	Do you have any missing teeth that you would like to be replaced to improve your smile and your bite?
☐	☐	Do you have an old, worn denture, or loose denture that looks false and feels false?
☐	☐	Have you noticed any changes in your facial structure since you started wearing dentures?
☐	☐	Have you ever considered dental implants?
☐	☐	Are you teeth stained or your gums red and swollen?
☐	☐	Do your gums bleed when brushing?
☐	☐	Do you get a bad taste in your mouth or around some of your teeth?
☐	☐	Are you concerned that you may have bad breath?
☐	☐	Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?