Felpham Dental

Medical Questionnaire

This questionnaire is confidential and no information you provide will be disclosed to a third party without your consent.

Title _____ Forename(s) _____

Surname _____ Date of Birth _____

Address _____

_____ Postcode _____

Tel. (Home) _____

Tel. (Mob) _____ e-mail clearly: _____

Please circle the appropriate answer. If you answer yes to any questions please give details at the bottom of the page.

ARE YOU:

1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?----------YES/NO
2. Taking any tablets, creams, ointments, injections, etc from your doctor?----------YES/NO
3. Taking now or within the last 2 years steroid medication?----------YES/NO
4. Allergic to any medicines, foods or materials? ----------YES/NO
5. Are you an expectant mother? ----------YES/NO

HAVE YOU:

1. Had rheumatic fever or chorea (St Vitus Dance)?----------YES/NO
2. Had jaundice, liver, kidney disease or hepatitis?----------YES/NO
3. Ever been told you have a heart problem such as angina, heart attack?----------YES/NO
4. Been treated for high or low blood pressure?----------YES/NO
5. Ever been treated with Bisphosphonate drugs - eg for osteoporosis?----------YES/NO
6. Had a bad reaction to a general or local anaesthetic?----------YES/NO
8. Had a joint replacement?----------YES/NO
9. Ever had a stroke,TIA,blackout,epilepsy,brain surgery?----------YES/NO
12. Been hospitalised?----------YES/NO
13. Been treated for cancer?----------YES/NO

DO YOU:

1. Have arthritis?----------YES/NO
2. Have a pacemaker, or have you had any form of heart surgery?----------YES/NO
3. Suffer from hay fever, eczema or any other allergy? ---------- YES/NO
4. Suffer from bronchitis, asthma or other chest condition?----------YES/NO
5. Suffer fainting attacks, giddiness, blackouts or epilepsy?----------YES/NO
6. Have diabetes or does anyone in your family have diabetes?----------YES/NO
7. Bruise easily or have you bled so much as to cause you to be worried following tooth extraction, surgery or injury? ----------YES/NO
8. Carry a medical warning card?----------YES/NO
9. Have any drug/tablet allergies?----------YES/NO

Are there any other aspects about your health that you think we should know about----------YES/NO

Please note your doctor's name and address. _____

Name and contact telephone number of an immediate family member in case of emergency

_____

If you answered **YES** to any question above please give details here and list any **medication** that you are taking:

Signed (patient/parent/guardian) ……. Date……

Getting to know you.

1. What is the particular reason for your visit today?

2 How do you usually feel before visiting the dentist?

Not at all anxious☐ Slightly anxious☐ Fairly Anxious☐ Very anxious☐ Extremely Anxious☐

2a If you feel anxious about your visit, what is it that worries you most?

3 How often do you usually attend the dentist?

Every 6 months ☐ Every year ☐ Every few years ☐ Only when in pain ☐

4. Concerning Smoking, which category best represents you?

Non-Smoker ☐ I smoke _____ cigarettes per day

5. How many units of alcohol do you consume in a week?

0 ☐ 1-5 ☐ 5-10 ☐ 10-20 ☐ 20-30 ☐ 30+ ☐

6. What is your occupation?

Are your teeth ever sensitive to hot, cold or sweet? YES/NO

Does food wedge between any of your teeth? YES/NO

Do your gums bleed easily or feel tender and irritated? YES/NO

Please indicate if you are interested in the following types of dental treatment

☐ Crown or bridgework ☐ Improving gum health

☐ Seeing the dental hygienist ☐ Dentures

☐ Dental implants ☐ Fissure sealants

☐ Tooth Whitening

How did you hear about the practice: web / newspaper/magazine advertising /friend/just passing?

Please tell us about any members of your family that you would like to join the practice.

Thank you.