

**Confidential**

**Family Dental Health Centre**  
*Dr Ian Henning BDS - Principal*  
*Dr Eman Mottaleb BDS, Dr Krystyna Kowalik BDS*  
**Medical and Dental History Questionnaire**

Please read and complete the three sections of this form, deleting where appropriate.

**GENERAL INFORMATION:**

<b>Mr/Mrs/Miss/MS</b> . . . . .	<b>Surname.</b> . . . . .
<b>First Name.</b> . . . . .	<b>Date of Birth.</b> . . . . .
<b>Address</b> . . . . .	<b>Home.</b> . . . . .
. . . . .	<b>Mobile</b> . . . . .
<b>Post code</b> . . . . .	<b>Work</b> . . . . .
	<b>E-mail Address</b> . . . . .
<b>Occupation</b> . . . . .	

**Parents or guardian for patients under 16 years of age** . . . . .  
.....

**How did you hear about us?** . . . . .

**Is there someone we can contact in the event of an emergency?**  
**Name** . . . . . **Tel** . . . . .

**(It is important that we have your GP details & your NHS Number)**  
**Name and address of doctor if known** . . . . .  
.....  
**NHS Number (you can get this from your GP) this is not the same as your NI number).** . . . . .  
.....

**Are you receiving treatment from your doctor at the moment and if so what for?** . . . . .  
.....  
.....

**Are you pregnant or nursing a child under 1 year?** . . . . .  
**If yes please state expected/Actual birth date** . . . . .



(How many units do you drink per week?)  
1 unit = A small glass of wine  
2 units = 1 Pint

**DENTAL HISTORY**

Have you come to this practice for relief of pain or with a specific problem?

Yes No

Have you ever had orthodontic treatment?

Yes No

Do you have any missing teeth?

Yes No

Do you wear dentures?

Yes No

Do you have any unpleasant odour or taste in your mouth?

Yes No

When was your last dental visit?

Date - .....

If NHS, are you exempt from paying NHS dental charges? Yes/No

If yes please state your Exemption with any certificate numbers.....

Are you satisfied with the whiteness of your teeth?

Yes No

Do you clench or grind your teeth during the Day or Night? (Please state which one)

Yes No

Do you now, or have you ever suffered with pain in your jaw joints, side of your face or your ears?

Yes No

**DECLARATION**

I have completed this pre clinical questionnaire to the best of my knowledge

Signature . . . . .

Date . . . . .

(Parent to sign if patient is under the age of 16 years)