Updated June 2020

Confidential

Family Dental Health Centre

Dr Ian Henning BDS - Principal

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Medical and Dental History Questionnaire

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

GENERAL INFORMATION:

Mr/Mrs/Miss/MS . . . .

Surname. . . . .

First Name. . . . .

Date of Birth. . . . .

Home. . . . .

Address . . . .

. . . .

Mobile . . . .

Work . . . .

Post code . . . .

E-mail Address . . . .

Occupation . . . .

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 . . . .

Have you ever had any of the following?

Heart problems	Yes	No
Lung problems (TB, asthma, emphysema)	Yes (please state)	No
Shortness of breath	Yes	No
Hepatitis, liver disease, jaundice	Yes (please state)	No
Arthritis	Yes	No
Joint replacement	Yes	No
Diabetes	Yes	No
Excessive bleeding	Yes	No
Blood problems, anaemia, leukaemia	Yes (please state)	No
Kidney problems	Yes	No
HIV positive	Yes	No
Heart attack	Yes	No
Pacemaker or artificial valve fitted	Yes (Please state)	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No
Fainting spells, convulsions, epilepsy	Yes (please state)	No
Cold Sores	Yes	No
COVID-19	Yes	No

Are you taking any Medication at the moment	Yes	No

If yes what are you taking? . . . .
. . . .
. . . .
. . . .
. . . .

Do you have any other medical conditions and if yes what are they? . . . . .
. . . .
. . . .

Have you ever been sick, shown allergy or told not to take any of the following?

Antibiotics	Yes	No
Pain medication	Yes	No
Aspirin	Yes	No
Dental anaesthetic	Yes	No

Other drugs or medication please state . . . .
. . . .
. . . .

Do you smoke or Vape (Please state which) (How many do you smoke a day)	Yes	No
Do you drink alcohol?	Yes	No

(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)