PRIVATE AND CONFIDENTIAL

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(Please complete as fully as possible)

TITLE: Dr. Mr. Mrs. Ms. Mst. Miss

SURNAME..

FORENAMES..

DATE OF BIRTH ....

OCCUPATION ....

ADDRESS: ....

....

Post Code: ....

TEL NO (Home**)**..(Work)..(Mobile)...............................

E-MAIL ADDRESS ....

NAME OF DOCTOR: ....**TEL:** ....

Please complete the following examination questionnaire as fully as possible. The information given together with details of any **treatment, pills, medicines, or drugs** you are receiving from your doctor will aid in assessing your Dental Health thoroughly and will become part of your dental records and will be held in strict confidence.

MEDICAL HISTORY:

1. Are you under treatment from your doctor, the hospital or clinic? ....
2. Do you wear a pace maker? ....
3. Have you ever had:

Heart complaints? ....

Rheumatic Fever? .... Heart Murmur? ....

High or low blood pressure?. ....

Hepatitis, Jaundice, liver or kidney complaints? ....

Epilepsy, fainting attacks, fits? ....

Diabetes or sugar problems? ....

Abnormal bleeding after extraction's, surgery or injury...

Problems after a general or local anaesthetic? ....

4. Are you allergic to penicillin, other medicines or tablets? ....
5. Are you expecting or nursing a baby? ....
6. Are you taking any medicines, pills or tablets? ....

....

7. Have you had any operations? ....
8. Do you suffer from **HIV** or **AIDS**? ....
9. Do you smoke? .... What quantity? ....
10. Is there anything else that would be valuable for us to know?

....

DENTAL HISTORY

11. When last did you have a comprehensive **Dental Examination**? ....

Did you have X-rays? ....How often did you visit the Dentist before then? ....

12. Who recommended you to our Practice? ....

13. Why did you want to change Dental Practices? ....

14. Do you have any fears or worries about Dental Treatment? ....
....

15. Do you have any Jaw pain / clicking while eating? ....

16. Are you aware of grinding your teeth while sleeping or under stress ....

17. Do you suffer from any ear or eye problems? ....

18. Do you have any concerns about your teeth and gums? ....

....

19. Do your gums bleed? .... If yes, when do they bleed? ....

20. Are you aware of any broken or painful teeth? ....

....

21. Is there anything about your teeth you want to change? ....

....

22. Are you happy with the colour of your teeth? ....
23. Are you concerned about Mercury in your fillings? ....
24. Are you aware of any mouth odour? ....If so, when? ....

Is there anything you wish to add? ....
....

SPORT/HOBBIES & OTHER INTERESTS

....

I give my consent for photographs to be taken which will form my dental records.
I give my consent to be contacted by email, telephone and text message.
I permit my information to be provided to another dental practice, hospital, dental laboratory or dental insurance scheme in the process or managing my dental care.

SIGNATURE: ....

DATE: ....

Kindly inform your Dental Surgeon of ANY changes to the details supplied.
Thank you for completing this questionnaire; please bring it with you to your first visit.
Our practice team looks forward to meeting you soon.