Dental Questionnaire ■ bayswater **dental centre**

Welcome to our practice....

Please answer these questions as completely as possible; it will greatly assist us to provide the best dental treatment for you.

NAME (Mr/Mrs/Miss/Ms/Other)(FIRST)..... .....(SURNAME).....
DOB.....FIRST SEEN.....
ADDRESS.....P/CODE.....
PHONE(HOME)..... MOBILE.....
OCCUPATION..... EMPLOYER.....
EMAIL ADDRESS.....
PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT.....
WHICH HEALTH FUND DO YOU BELONG TO? .....MEMBER ID.....No.....
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?.....
HOW WOULD YOU LIKE TO BE REMINDED FOR RECALLS: Recall Card……..SMS……..Email……..(Please Tick)
HOW WOULD YOU LIKE TO BE REMINDED FOR APPOINTMENTS: Phonecall……..SMS……..Email…….(Please Tick)

Medical Questionnaire – Private & Confidential

The state of your health may have a very significant effect on your dental care:
Please answer these questions fully or discuss them with your dentist.

	Y	N
• Are you receiving any medical treatment at present?	☐	☐
• Have you ever been in hospital?	☐	☐

- Name of your medical practitioner/specialist.....
- Please list any medications you are taking including dosage (including aspirin, oral contraceptive, HRT, herbal, cortisone/steroids, Warfarin/Heparin,(Blood thinning) medicines or 'over the counter' remedies).....
  .....
  .....

Please indicate if you have **ever** had any of the following:

	Y	N		Y	N
Any heart (cardiac) condition/treatment	☐	☐	Rheumatic Fever	☐	☐
If YES, what……..			Epilepsy	☐	☐
A cardiac pacemaker	☐	☐	Thyroid Disease	☐	☐
High or low blood pressure(please highlight)	☐	☐	Tuberculosis (TB)	☐	☐
Stroke or blood clotting issues	☐	☐	Asthma/Bronchitis/lung conditions	☐	☐
Anti-coagulant (blood thinners) treatment	☐	☐	Any nervous system disorder	☐	☐
Blood disorders	☐	☐	Gastric Ulcer	☐	☐
Excessive bruising or bleeding	☐	☐	Radiation (x-ray) therapy for cancer	☐	☐
Osteoporosis or low bone density	☐	☐	Allergy or reaction to any medicine?		
Diabetes, Type 1 or Type 2	☐	☐	(including Penicillin or any antibiotics)	☐	☐
Hepatitis, jaundice, liver dis, HIV/ AIDS	☐	☐	Allergy to any foods, chemicals or substance?		
Neck/jaw or shoulder damage or pain	☐	☐	(such as chlorine, latex, antiseptics)	☐	☐
Joint replacement surgery	☐	☐	Transplanted organ or bone marrow	☐	☐

What & when……

Do you smoke/vape? ☐ ☐ If yes, for how long?.....
What do you smoke? (Cigarettes/ pipe/ cigars/other).....
How much/often do you smoke?.....per day
Have you ever required any treatment for smoking related diseases or conditions? Y ☐ N ☐
Do you suffer from any illness or carry any infectious diseases? Y ☐ N ☐
FEMALES: Are you pregnant? Y ☐ N ☐ If so, when are you due?.....
Are you breastfeeding Y ☐ N ☐

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Signed..... Date.....
(Parent or guardian if under 18 years)