PATIENT HISTORY

THIS INFORMATION IS STRICTLY CONFIDENTIAL AND IS REQUIRED TO ENSURE YOUR SAFE AND EFFECTIVE TREATMENT. PLEASE RESPOND FULLY TO ALL QUESTIONS.

THANK YOU

MEDICAL HISTORY

FULL NAME ....
HOME ADDRESS .... TEL..
WORK ADDRESS.. TEL..
DATE OF BIRTH .... E-MAIL...
MARRIED () SINGLE () PROFESSION ....

OVERALL HEALTH STATE: EXCELLENT (), GOOD () POOR ().
NAME AND PHONE NUMBER OF GP...

ARE YOU TAKING ANY MEDICATION REGULARLY? YES () NO ().
PLEASE SPECIFY ....

ARE YOU TAKING ANY OF THE FOLLOWING MEDICINES?
ANTICOAGULANTS () ASPIRIN () SALOSPIR ()..

ARE YOU TAKING ANY MEDICATION FOR OSTEOPOROSIS?...

DO YOU HAVE ANY MAJOR HEALTH PROBLEMS? YES () NO ().
PLEASE DESCRIBE...

HAVE YOU EVER BEEN TREATED FOR

() HEART PROBLEMS
() RHEUMATIC FEVER
() HIGH/LOW PRESSURE
() PEPTIC ULCER
() IMMUNE SYSTEM PROBLEMS
() LUNG DISEASES
() RENAL DISEASES
() VENEREAL DISEASES
() ANAEMIA
() DEPRESSION
() AIDS
() THYROID PROBLEMS
() TUBERCULOSIS
() JAUNDICE
() HEPATITIS
() OSTEOPOROSIS
() STROKE
() SINUSITIS
() CHRONIC COUGH
() ARTHRITIS
() GLAUCOMA
() DIABETES
() EPILEPSY
() ASTHMA

HAVE YOU EVER UNDERGONE RADIATION THERAPY OR CHEMOTHERAPY FOR CANCER? YES () NO ().

ARE YOU ALLERGIC TO LOCAL ANAESTHETICS? YES () NO ()

ARE YOU ALLERGIC TO PENICILLIN (), CODEINE (), ASPIRIN ()? ARE YOU ALLERGIC TO ANYTHING ELSE?..

HAVE YOU EVER HAD SERIOUS PROBLEMS WITH HEAVY BLEEDING AFTER A TOOTH EXTRACTION? YES () NO ()

DO YOU BLEED EXCEEDINGLY? YES () NO ()

DO YOU FAINT EASILY? YES () NO ()

HAVE YOU EVER HAD A SERIOUS ACCIDENT IN YOUR HEAD OR NECK? YES () NO ()

HAVE YOU EVER CONSULTED OR HAVE YOU BEEN TREATED BY A PSYCHIATRIST OR PSYCHOLOGIST? YES

() NO ().

(FOR WOMEN ONLY) ARE YOU PREGNANT? YES () NO (). IN WHICH MONTH? ....

DO YOU SMOKE? YES ( ), NO ( ), HEAVILY ( ), SOCIALLY ( )

DENTAL HISTORY

WOULD YOU LIKE TO ADD ANYTHING ELSE REGARDING YOUR HEALTH?..

....

WHAT IS THE MAIN PROBLEM FOR WHICH YOU HAVE VISITED US? ....

....

WHEN WAS THE LAST TIME YOU WENT TO A DENTIST? ....
....WHY? ....

HAVE YOU EVER HAD PROBLEMS OR COMPLICATIONS DURING OR FOLLOWING DENTAL TREATMENT? YES () NO ()
IF YES, PLEASE DESCRIBE ....

DO YOUR GUMS BLEED WHEN BRUSHING? YES () NO ()
HOW OFTEN DO YOU BRUSH YOUR TEETH?...

DO YOU FLOSS? YES () NO ()

HAVE YOU BEEN SHOWN HOW TO BRUSH YOUR TEETH AND FLOSS? YES ( ), NO ( )
WHO RECOMMENDED OUR CLINIC? ....

ARE YOU EXPERIENCING OR HAVE YOU EXPERIENCED IN THE PAST? MARK (v) IF YES

() A CLICKING SOUND WHEN OPENING OR CLOSING YOUR JAW
() DO YOU CLENCH OR GRIND YOUR TEETH DURING THE DAY OR NIGHT
() PAIN, IN OR AROUND THE EAR AND CHEEKS
() SPLINTS FOR THE TREATMENT OF TEMPOROMANDIBULAR JOINT DYSFUNCTION
() WOUNDS OR PAINFUL AREAS IN YOUR MOUTH
() BAD MOUTH ODOUR OR DYSGEUSIA
() DO FOOD PARTICLES GET WEDGED BETWEEN YOUR TEETH
() ORTHODONTIC TREATMENT

WOULD YOU BE INTERESTED IN THE COSMETIC RESTORATION AND WHITENING OF YOUR TEETH?
YES ( ), NO ( )

DATE ....

SIGNATURE ....