

# Medical and dental questionnaire



Dear \_\_\_\_\_

In order to provide the best care for you, we would be grateful if you could complete this confidential questionnaire.

## About you

Title: Mr/Mrs/Miss/Ms/Other \_\_\_\_\_ Full name \_\_\_\_\_

Address \_\_\_\_\_

Contact numbers \_\_\_\_\_ Post code \_\_\_\_\_

Home \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Work \_\_\_\_\_ Occupation \_\_\_\_\_

Mobile \_\_\_\_\_ Expectant mother Yes/No \_\_\_\_\_

Email \_\_\_\_\_ If so, expected date \_\_\_\_\_

## Medical health

Approximately how long since you last received dental treatment? \_\_\_\_\_

Your doctor's name and address \_\_\_\_\_

### Are you

	Yes	No	Details
1. attending or receiving treatment from a doctor, hospital, clinic or specialist?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. taking any regular medication? (tablets, creams, etc. prescribed or otherwise)	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. taking the oral contraceptive pill?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. taking, or have you taken, steroids in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. allergic to any medicines, foods or materials?	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Have you

	Yes	No	Details
1. ever had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. ever been told that you have a heart murmur, heart problem or had a pacemaker fitted?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. ever had angina, high/low blood pressure or anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. bled excessively following a tooth extraction, surgery or injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. had jaundice, liver, kidney disease or hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. had a bad reaction to a general or local anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. had a joint replacement or any other implant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. ever been hospitalised?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. cause to believe you may be infected with HIV?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. ever had brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. had growth hormone treatment before the mid 1980's?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. a close blood relative with Creutzfeldt Jakob Disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Do you**

**Yes No**

**Details**

- 1. suffer from bronchitis, asthma or other chest condition?
- 2. have fainting attacks, giddiness, blackouts or epilepsy?
- 3. have diabetes, or does anyone in your immediate family?
- 4. carry a medical warning card?
- 5. suffer from hayfever, eczema or any other allergy?
- 6. suffer from arthritis?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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Are there any other aspects concerning your health that you think the dentist ought to know about?

<input type="checkbox"/>	<input type="checkbox"/>
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**Dental health**

**Dental history**

- 1. How long since you last visited the dentist?
- 2. Have you been a regular attender in the past? (six monthly/annually)
- 3. Have you recently had professional instruction on cleaning and maintaining your teeth and gums?
- 4. Have you had previous periodontal (gum) treatment?
- 5. Have you had difficult extractions in the past?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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**Your teeth and gums**

- 1. Do you have any pain associated with your teeth?
- 2. Do you have sensitive teeth?
- 3. Do your gums bleed after brushing/flossing?
- 4. Are any of your teeth loose?
- 5. Are you aware of clenching/grinding your teeth?
- 6. Are you happy with the appearance of your teeth?
- 7. Do you wear dentures? If so, are you happy with the: appearance; fit; function of your dentures?
- 8. Do you suffer from mouth ulcers/cold sores?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
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**Other considerations**

- 1. Do you play a physical sport, e.g. rugby, hockey?
- 2. How many cigarettes/cigars do/did you smoke a day?
- 3. How many units of alcohol do you consume in a typical week?
- 4. Are you very apprehensive about dental treatment?
- 5. Are you interested in replacing any dark fillings?
- 6. Are you interested in tooth whitening/bleaching?
- 7. Is there anything else regarding your dental health that you would like us to know?
- 8. How did you hear about The Buckley Dental Practice?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Incorporating  
The Bromley Orthodontic Clinic and  
The Bromley Implant Centre



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