

Medical and dental questionnaire



About you

Title: Mr / Mrs / Miss / Ms / Other _____ Full Name _____

Home Tel. _____ Mobile _____

Work Tel. _____ Email _____

Preferred method of contact Home Tel. Mobile
 Work Tel. Email
Occupation _____

How did you hear about The Buckley Practice? _____

Medical health

Your doctor's name and address _____

Are you

Yes No Details

1. attending or receiving treatment from a doctor, hospital, clinic or specialist? _____

2. taking any regular medication? (tablets, creams etc. prescribed or otherwise) _____

3. taking the oral contraceptive pill? _____

4. taking, or have you taken steroids in the last two years? _____

5. allergic to any medicines, foods or materials? _____

Have you

1. ever had rheumatic fever? _____

2. been told that you have a heart murmur, heart problem or had a pacemaker fitted? _____

3. ever had angina, high / low blood pressure or anaemia? _____

4. bled excessively following a tooth extraction, surgery or injury? _____

5. had a stroke? _____

6. had jaundice, liver, kidney disease or hepatitis? _____

7. had a bad reaction to a general or local anaesthetic? _____

8. ever been hospitalised? _____

9. cause to believe you may be infected with HIV? _____

10. ever had brain surgery? _____

11. had growth hormone treatment before the mid 1980's? _____

12. a close blood relative with Creutzfeldt Jakob Disease? _____

Do you

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 hay fever, eczema or any other allergy?
6. suffer from arthritis?

Yes No Details

<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"/>	_____

About you

1. how many cigarettes/cigars do/did you smoke a day?
2. how many units of alcohol do you consume in a typical week?
3. do you play contact sport, e.g. rugby, hockey?
4. Are you very apprehensive about dental treatment?
5. Are there any other aspects concerning your health that you think the dentist ought to know about?

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Dental Health

Dental History

1. how long since you last visited the dentist?
2. have you been a regular attendee in the past? (6 monthly / annually)
3. have you recently had professional instructions 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?

Yes No Details

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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. do you wear dentures?
7. if so are you happy with the appearance, fit and function of your dentures?
8. do you suffer from mouth ulcers / cold sores?
9. do you have a dry mouth?
10. is there anything else regarding your dental health that you would like us to know?

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Date _____

Signed _____

Dentist's Signature _____