Hackenthorpe
Dental Health Centre

Dr Andrew Cadman BDS
Hackenthorpe Dental Health Centre,
Main Street, Hackenthorpe,
Sheffield, S12 4LB

Confidential Medical Questionnaire

In order to provide you with the most appropriate and safest treatment, your dentist needs to know about any previous or current medical conditions, since many of them can affect your dental treatment. Please complete this questionnaire and bring it along with you at your first visit. We will update your records at each new course of treatment.

General Information

Dr Mr Mrs Ms Miss

First Name ______________________ Surname ______________________

Date of Birth ______________________

Parent or guardians name (If under 16) ______________________

Address: Home ______________________

______________________ Postcode ______________________

Address: Business ______________________

______________________ Postcode ______________________

Telephone : Home ______________________ Business ______________________

Are you exempt from NHS charges? Yes No Exemption

Doctor's Name ______________________

Doctor's Address ______________________

Doctor's Telephone Number ______________________

Medical History

Please tick Yes or No to the following questions. Have you ever had, or do you suffer from, any of the following:

Rheumatic Fever	Yes	No
Artificial Heart Valve	Yes	No
Heart Murmur	Yes	No
Pacemaker	Yes	No
Heart Attack	Yes	No
Angina	Yes	No
High Blood Pressure	Yes	No
Other heart problems	Yes	No
Excessive bleeding	Yes	No
Blood trouble, anaemia, leukaemia	Yes	No
Chest problems (TB, asthma, emphysema)	Yes	No
Hepititis, liver disease, jaundice	Yes	No
Asthma, eczema, hayfever or other allergy	Yes	No
Are you allergic to penicillin or other medicine	Yes	No
Fits, faints or epilepsy	Yes	No
Diabetes	Yes	No
Kidney problems	Yes	No
Positive HIV test	Yes	No
Any serious illness or operation	Yes	No
Are you pregnant, trying for or nursing a baby	Yes	No

If yes expected / born ______________________

Anything else of medical importance Yes No

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____

How much do you: a) Smoke________ per day

b) Drink ________per day

In an emergancy, is there someone we can contact?

Name ______________________

Telephone number ______________________

Are you taking any medications, tablets, ointments or injections?

Please specify ______________________

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Dental History

When did you last attend a dental surgery? ______________________________

How do you feel about your mouth? ______________________________

How do you want us to help you? ______________________________

Is there anything that you are paticularly worried about? ______________________________

Are you prepaired to work with us to help you keep your teeth for life? ______________________________

Do you have any of the following:

Sensitive teeth	Yes	No	Unreplaced missing teeth	Yes	No
Unpleasant odour or taste in your mouth	Yes	No	Aching teeth	Yes	No
Loose teeth	Yes	No	Bleeding gums	Yes	No
Tartar, stain or build up	Yes	No	Pain in the front of your face made worse by coughing		
Broken teeth or fillings	Yes	No		Yes	No
Teeth sensitive to pressure	Yes	No	Dentures	Yes	No

Appearance

Are you happy with your teeth and their appearance?	Yes	No
Are you self conscious of your teeth when you smile?	Yes	No
Do you have any discoloured teeth or fillings that concern you?	Yes	No
Are you concerned about wearing dentures?	Yes	No

Occlusion

Do you grind or clench your teeth?	Yes	No
Do your jaws or teeth ache on waking?	Yes	No
Do you have headaches, neck, shoulder or back pains?	Yes	No
Have you had pain in your jaw joints or sides of your face?	Yes	No
Have your jaws clicked or popped when you open your mouth?	Yes	No
Do you chew on one side of your mouth?	Yes	No

How did you find out about us?

Yellow Pages Newspaper

Word of Mouth Other (please specify) ______________________________

I have completed this pre-clinical examination questionnaire to the best of my knowledge:

Signed ______________________ Date ____________________

(Parent if patient is under 16)

Date ________________ Changes ______________________________

Date ________________ Changes ______________________________

Date ________________ Changes ______________________________

Date ________________ Changes ______________________________

Date ________________ Changes ______________________________