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	Any serious illness or operation	Yes	No
Artificial Heart Valve	Yes	No	Are you pregnant, trying for		
Heart Murmur	Yes	No	or nursing a baby	Yes	No
Pacemaker	Yes	No	If yes expected / born _____		
Heart Attack	Yes	No	Anything else of medical importance	Yes	No
Angina	Yes	No	_____		
High Blood Pressure	Yes	No	_____		
Other heart problems	Yes	No			
Excessive bleeding	Yes	No	How much do you: a) Smoke_____ per day		
Blood trouble, anaemia, leukaemia	Yes	No	b) Drink _____per day		
Chest problems (TB, asthma, emphysema)	Yes	No			
Hepititis, liver disease, jaundice	Yes	No	In an emergancy, is there someone we can contact?		
Asthma, eczema, hayfever or other allergy	Yes	No	Name _____		
Are you allergic to penicillin or other medicine	Yes	No	Telephone number _____		
Fits, faints or epilepsy	Yes	No			
Diabetes	Yes	No	Are you taking any medications, tablets, ointments or injections?		
Kidney problems	Yes	No	Please specify _____		
Positive HIV test	Yes	No	_____		

Covid Status

Have you been diagnosed with coronavirus? Yes No

Have you been in contact with someone with confirmed coronavirus? Yes No

Is there anyone in your household self-isolating? Yes No

If so why? _____

_____

Have you had a temperature (ie greater than 37.8 degrees) in the last 14 days? Yes No

Have you or do you have a new persistent dry cough in the last 14 days? (not a longstanding dry cough of non covid origin) Yes No

Are you in a vulnerable group or at increased risk of covid 19 eg 70 or older or under 70 with underlying health condition? Yes No

Please confirm consent to treatment at our practice Yes No

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 _____

Once complete, please email this to reception.hackenthorpedental@nhs.net