Medical Form

All information is strictly confidential.

D100

Personal Details

Title:

First name: Last name: Date of birth:

Home address: Postcode:

Mobile no: Phone no: Email:

Occupation: Work phone no:

Work address: Work postcode:

Medical Questionnaire

Name and phone number of General Medical doctor:

Are you receiving any medical treatment from the doctor, hospital or clinic? ☐ Yes ☐ No If yes please give details:

Are you taking any medication? ☐ Yes ☐ No If yes please give details:

Are you taking any vitamin supplements? ☐ Yes ☐ No If yes please give details:

If you have had any of the following conditions please place a tick next to the condition:

☐ Asthma	☐ High blood pressure	☐ Low blood pressure	☐ Bronchitis
☐ Heart attack	☐ Replacement heart valve	☐ Rheumatic fever	☐ Heart valve
☐ Angina	☐ Liver disease	☐ Tuberculosis	☐ Sinus problems
☐ Heart disease	☐ Stroke	☐ Heart murmur	☐ Epilepsy
☐ Diabetes	☐ Hepatitis	☐ Hip / knee replacement	☐ HIV / Aids

Are you pregnant? ☐ Yes ☐ No If yes please give due date:

Do you take contraceptive pills? ☐ Yes ☐ No

Do you suffer from allergies? ☐ Yes ☐ No If yes please give details:

Do you smoke? ☐ Yes ☐ No If yes how many per week:

Do you suffer from depression? ☐ Yes ☐ No

Is there anything else you would like to tell us? ☐ Yes ☐ No If yes please give details:

Signature: Date:

Periodontal Assessment Questionnaire

The following questionnaire will enable us to develop a treatment plan to maximise your treatment outcome.
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Please answer the following questions:

When was your last dental hygiene appointment?

Do your gums ever bleed?	☐ Yes	☐ No
Are you self-conscious about your breath?	☐ Yes	☐ No
Have you noticed that your gums are receding?	☐ Yes	☐ No
Do you have loose teeth?	☐ Yes	☐ No
Do you have teeth that have changed position?	☐ Yes	☐ No
Are you teeth becoming more sensitive to temperatures or touch?	☐ Yes	☐ No
Are you taking prescribed medication?	☐ Yes	☐ No
Have you been diagnosed with active bacterial gum infection in the past?	☐ Yes	☐ No
Have you ever been diagnosed with periodontal disease?	☐ Yes	☐ No
Do you smoke or use tobacco?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No

If yes how many per day?

If yes how many times per week?

Do you have any known risk of heart disease such as:

☐ High Cholesterol ☐ High blood pressure ☐ Family history of heart disease ☐ Stress

Signature:

Date:

Smile Profile

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Please answer the following questions:

Are you happy with your smile? ☐ Yes ☐ No

What do like most about your smile?

What do you like least about your smile?

How important is your dental health to you?
1: Not important, 5: Very important
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How would you rate your current dental health?
1: Very poor, 5: Very good
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please tick the following statements you consider to be true:

- ☐ I wish the gaps between my teeth were smaller
- ☐ I wish I had a wider smile
- ☐ I wish my teeth were the same colour
- ☐ I wish my teeth were whiter
- ☐ I wish my teeth were straighter
- ☐ I am worried about the cracks in my teeth
- ☐ I do not smile because of my teeth
- ☐ I would like to replace missing teeth
- ☐ I think my gums show too much when I smile
- ☐ I think my teeth are too large/too small
- ☐ I am unhappy about my smile
- ☐ I suffer with headache/jaw pain
- ☐ I have a click in my jaw
- ☐ I have discomfort when chewing
- ☐ I have fractured teeth in the past
- ☐ I am aware of clenching and grinding my teeth
- ☐ I would like to improve my lines and wrinkles
- ☐ I would like to enhance my lips
- ☐ I don't know what the dentist can do to improve my smile
- ☐ I am concerned that I can not afford the dentistry that I would like
- ☐ I dislike the old crowns that do not match the other teeth
- ☐ I dislike the crowns that have black lines around the margins

What are you hoping to achieve from your dental visit today?

What are your expectations of us?

Signature: Date: