dene DENTAL PRACTICE

www.denedental.com

Dr. Vik Shah BDS(Lond) LDSRCS (Eng)

CONFIDENTIAL MEDICAL & DENTAL HISTORY FORM

To help your Dental team provide the best and safest care, please complete the following questionnaire.

Title :	**Full Name :**
Date of Birth :	**Occupation :**
Mobile Number :	**Email :**
How did you hear about Dene Dental Practice:	
Doctor's Name & Surgery :	
Surgery Telephone No :	

HAVE YOU EVER SUFFERED FROM :	**NO**	**YES**	**DETAILS**
Any Heart Problems: Heart surgery Angina Heart attack Pacemaker Stroke High or low blood pressure Any other heart condition			
Any chest problems: Asthma Bronchitis Any other chest conditions			
Do you smoke? If 'YES', how many?			
Are you pregnant?			
Diabetes : If yes, how is it controlled: diet, tablets, insulin			
Epilepsy, fainting attacks, giddiness or blackouts			
Hiatus hernia or any stomach problems			
Jaundice, Liver or Kidney disease			
Hepatitis or HIV or any other blood disorders			
Easy bruising or prolonged bleeding following injury, tooth extraction or surgery			
Osteoporosis: If yes, do you take Bisphosphonates (tablets or injections) and for how long have you been on them			
Arthritis			
HAVE YOU :	**NO**	**YES**	**DETAILS**
Had a joint replacement			
Rheumatic Fever			
Bad reaction to a Local or General anaesthetic			
Taken Steroids - now or in the past 2 years			
DO YOU :	**NO**	**YES**	**DETAILS**
Carry a warning card or an Epipen			
Have any Allergies to any medications or materials? Eg: antibiotics, latex.			
Take any Medications: Please list all medications including over the counter / herbal / homeopathic.			

Please turn over

PAST DENTAL HISTORY

When did you last have a dental check-up?
When did you last have dental X-rays taken?
Have you ever seen a Dental Hygienist? *Regularly / Occasionally / Never*
What prompted you to seek dental care today?

	NO	YES
Have you experienced any discomfort from your teeth recently? *details:*		
Are your teeth sensitive to hot or cold? *details:*		
Are you aware of clenching or grinding your teeth? *details:*		
Do your jaw joints ever hurt or click? *details:*		
Do your gums bleed easily or feel tender? *details:*		
Are you troubled with bad breath or a bad taste? *details:*		
Anything else you would like to mention? *details:*		
Are you happy with the state of your teeth and smile?		
WE PROVIDE TEETH WHITENING, TEETH STRAIGHTENING & NON-INVASIVE COSMETIC SMILE IMPROVEMENT		
Apart from assessing your Basic Dental Fitness would you like to know of other options to improve your Teeth/Smile?		

I consent to proceed with the dental care at Dene Dental Practice.

Signature : Date : Signed by Self / Parent / Guardian *please delete as appropriate*