**Dental History**

To be completed by the patient. Please tick **YES** or **NO**. If ‘**YES**’ please give full details of dates, diagnosis and operations.

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **YES** | **NO** | **Comment** |
| Are you anxious of dental treatment? |  |  |  |
| Have you had an unfavorable dental experience? |  |  |  |
| Have you ever had complications from past dental treatment? |  |  |  |
| Have you ever had difficulty getting numb or had any reactions to local anesthetic? |  |  |  |
| Have you ever had braces, orthodontic treatment or had your bite adjusted? |  |  |  |
| **SMILE CHARACTERISTICS** |  |  |  |
| Is there anything about the appearance of your teeth that you would like to change? |  |  |  |
| Have you ever whitened your teeth? |  |  |  |
| Have you felt uncomfortable or self-conscious about the appearance of your teeth? |  |  |  |
| Have you been disappointed with the appearance of previous dental work? |  |  |  |
| **BITE AND JAW JOINT** |  |  |  |
| Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) |  |  |  |
| Have your teeth changed in the last 5 years, become shorter, thinner or worn? |  |  |  |
| Are your teeth crowding or developing spaces? If yes, please specify |  |  |  |
| Do you clench your teeth in the daytime or make them sore? |  |  |  |
| Do you have any problems with sleep or wake up with an awareness of your teeth? |  |  |  |
| Do you wear or have you ever worn a bite appliance? |  |  |  |
| **TOOTH STRUCTURE** |  |  |  |
| Have you had any cavities within the past 3 years? |  |  |  |
| Does the amount of saliva in your mouth seem reduced or do you have difficulty swallowing any food? |  |  |  |
| Do you feel or notice any holes on the biting surface of your teeth? |  |  |  |
| Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? |  |  |  |
| Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? |  |  |  |
| Do you get food caught between any teeth? |  |  |  |
| **GUM AND BONE** |  |  |  |
| Do your gums bleed when brushing or flossing? |  |  |  |
| Have you ever been treated for gum disease or been told you have lost bone around your teeth? |  |  |  |
| Have you ever noticed an unpleasant taste or odor in your mouth? |  |  |  |
| Is there anyone with a history of periodontal disease in your family? |  |  |  |
| Have you ever experienced gum recession? |  |  |  |
| Have you ever had any teeth become loose on their own, or do you have difficulty eating an apple? |  |  |  |
| Have you experienced a burning sensation in your mouth? |  |  |  |

**Medical History**

Please tick **YES** or **NO**. If ‘**YES**’ please give full details of dates, diagnosis and operations.

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | **YES** | **NO** | **Comment** |
| **Are you allergic to anything?** (including ,medicine, latex, silicone, elastoplast, micropore tape, food, metal) |  |  |  |
| Have you ever had an anesthetic or sedation? |  |  | General Local |
| Have you ever had an adverse reaction to a local/general anesthetic/sedation? |  |  |  |
| Are you currently taking any medication? (including contraceptive pill ,implant ,injection/HRT) |  |  |  |
| Are you taking any vitamin/mineral/herbal preparations? |  |  |  |
| Have you ever taken blood thinning tablets or injections (Regular Aspirin User/Warfarin/Heparin) |  |  |  |
| Have you experienced any excessive bleeding/heavy periods/bruising in the past? |  |  |  |
| Have you had a history of blood clots, DVT or a pulmonary embolism? |  |  |  |
| Have you ever had or received treatment for Anaemia / Sickle cell (trait or disease) / Thalassaemia |  |  | Anaemia / Sickle Cell (trait or disease) / Thalassaemia |
| Have you ever had high or low blood pressure? |  |  |  |
| Have you ever had a blood transfusion? |  |  |  |
| Have you been diagnosed with Hepatitis A, B or C or HIV? |  |  |  |
| Have you ever had a stroke, TIA’s, Heart attack, Chest pain, Angina? |  |  |  |
| Have you ever had a heart murmur? |  |  |  |
| Have you ever had an ECG? If so, was there any abnormality? |  |  |  |
| Do you suffer from asthma? |  |  | If yes have you had any oral steroid treatment in the last year? |
| Have you ever suffered from any autoimmune conditions? |  |  | e.g MS/SLE/Behcets/ |
| Do you suffer from any abnormalities of the nervous system? e.g. epilepsy |  |  |  |
| Do you suffer from diabetes? If yes, what treatment are you having? |  |  | Diet / Tablet / Insulin Controlled |
| Have you had any thyroid problems? Over or under active? |  |  | If so, what treatment have you received? |
| Have you ever seen a psychiatrist/psychologist? When? |  |  |  |
| Have you ever been given anti-depressant or anxiety treatment? Last prescribed when? Who was this prescribed by (GP/Other)? |  |  |  |
| Do you drink alcohol? |  |  | How many units a week? |
| Do you smoke?  If recently stopped, when? |  |  | I smoke ……..… per day for …….…… years  Stopped smoking (month/yr)……..……/……………… |
| Do you have any other disabilities that may be relevant during your care? |  |  |  |

**Patient Declaration**

I confirm that I have completed the above medical/dental history and that it is accurate and complete. I understand that withholding any medical information can be detrimental to my health and safety if I decide to proceed with treatment.

**I also agree to the terms and conditions stated in the Patient Registration form.**

**Patient Print Name:** …………………………………………………………………………….**Date**: …………………

**Patient Signature**: ……………….……………………