

Confidential medical history questionnaire

Welcome to Academy Dental Care, in order to help us meet all of your dental health care needs, please complete the following confidential medical history form. Please ask a member of our team if you need any further assistance or have any questions.

Personal details

Title Mr Mrs Miss Ms Sex M F

Full Name D.O.B Home Tel. Work Tel.

Email Address Occupation Mobile Tel.

Please tick this box if you would prefer us not to contact you via email with special offers that we believe may be of interest to you

Address Post Code

How would you prefer to receive correspondence from Academy Dental Care? By email By post By SMS

Approx. date of your last dental visit

Doctor's details

Name Contact Tel.

Address Post Code

Medical history - do you have or have you had any of the following:

	Yes	No		Yes	No
Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	Liver or kidney problems including hepatitis/ jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Blood refused by the Blood Transfusion Service?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	A joint replacement or other implant?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting attacks/ giddiness/ blackouts?	<input type="checkbox"/>	<input type="checkbox"/>
Brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/ migraines?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to local or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores?	<input type="checkbox"/>	<input type="checkbox"/>	Treatment that required you to stay in hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Gastric disease?	<input type="checkbox"/>	<input type="checkbox"/>	Please tick or tell your dentist if you are HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Drug dependence?	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? If yes, how many cigarettes do you smoke on average in a week?	<input type="text"/>	
Heart condition including heart attack/ heart murmur/ angina?	<input type="checkbox"/>	<input type="checkbox"/>	On average, how many units of alcohol do you drink in a week?	<input type="text"/>	
High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Are you allergic to any medicines, tablets, substances or latex?	<input type="text"/>	
TB or chest problems including asthma/ bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever or Chorea/ St Vitus' Dance?	<input type="checkbox"/>	<input type="checkbox"/>			

Please provide details of any medication you are taking

Female Patients Only

Are you pregnant? Yes No

Are you taking the oral contraceptive pill? Yes No

Dental history

What is the reason for your dental visit?

What is your primary dental concern?

When would you like to start any treatment?

Have you had any serious problem with dental treatment? If so please explain:

Has any experience at the dentist made you wish not to return? If so please explain

Dental health

How often do you brush your teeth?

How often do you floss?

What type of toothbrush do you use?

Electric

Manual

Do you avoid brushing any part of your mouth because of pain? Yes (please provide detail)

No

If yes, please provide details

	Yes	No		Yes	No
Do you ever feel that you don't have fresh breath?	<input type="checkbox"/>	<input type="checkbox"/>	Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you clench or grind your jaws while sleeping or in the day?	<input type="checkbox"/>	<input type="checkbox"/>	Do your gums feel tender or swollen?	<input type="checkbox"/>	<input type="checkbox"/>
Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	Do you usually have many cavities?	<input type="checkbox"/>	<input type="checkbox"/>
			Do you lose fillings or break fillings?	<input type="checkbox"/>	<input type="checkbox"/>

Can we help you with any of the following?

We respect your right to choose the level of care that fits your needs. We've found that many adults are unaware that problems even exist. There are rarely symptoms (pain, bleeding) associated with the ageing and deterioration of teeth and gums, until it is far too late. With your permission we would like to explain the choices available to achieve long-term health and beauty for your existing natural teeth.

Please tick all that apply

- I want my teeth to look good, feel good and last for a long time.
- I am interested in spreading the cost of my treatment over time to make the cost more manageable.
- I am interested in a plan for long-term dental health. However, I am currently unable to pursue this and would appreciate help with emergencies and cleanings for now.
- Although I am not interested in a plan for long-term dental health, I do desire a clinic who will treat teeth in need of immediate/ emergency attention, as well as keep me up to date on cleanings.

Cosmetic/ aesthetic evaluation

Please rate how happy you are with the appearance of your smile? (1 is very unhappy, 10 is very happy)

Would you like to have whiter teeth? Yes No

Would you like to have straighter teeth? Yes No

Would you like to replace your mercury fillings with white fillings to make them less visible?

What, if anything, would you change about your smile?

How did you hear about Academy Dental Care?

Please provide detail

Cancellation & Missed Appointments

Should you need to change your appointment time or date, we simply ask for at least 24 hours notice for treatments taking less than an hour and 48 hours notice for treatments taking an hour or more.

I certify I have read and understood all information provided and have answered accurately. I understand that any incorrect information can be dangerous to my health and I will inform my dentist of any changes. I understand the Academy Dental Care Cancellation and Missed Appointment Policy.

I agree to be responsible for the payment in full of any treatment and service rendered on my behalf.

Signed

Patient/ Parent/ Guardian

/ /

Date

Dentist

/ /

Date