When was your last dental visit? ______________________

When did you last have dental x-rays taken? ______________________

How often do you brush your teeth? ______________________

How often do you floss? ______________________

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any trauma to your jaw?	☐	☐	☐
Have you ever had any implant surgery ?	☐	☐	☐

If you answered yes to the last question, who performed the surgery and when was it done?

______________________ Date ______________________

Are you being followed-up by a dental specialist? ______________________

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)? ☐ ☐ ☐

Is there anything about the appearance of your teeth you would like to change? ______________________

Please list anything not mentioned above regarding your past dental history:

____

____

Title ______ **First Name** ______ **Surname** ______
Health Card Number ______ **Email** ______
Date of birth ______ **Occupation** ______ **Employer** ______
Address ______ **Referred By** ______
______ **Postal Code** ______
Tel Contact **Home:** ______ **Work:** ______
Mobile: ______
Emergency Contact ______ **Emergency Contact Number** ______

Are you being treated for any medical conditions at the present time or have been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? ______

When was your last medical check-up? ______

Have there been any changes in your general health in the last year?
Yes ☐ No ☐ Not Sure☐

If yes, please explain ______

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list ______

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications ______
Latex/Rubber Products ______
Other (e.g. Hayfever, Foods) ______

Have you ever had an uncommon or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you have or have you ever had asthma?
Yes ☐ No☐ Not Sure ☐

______

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? ______

Do you have a prosthetic or an artificial joint?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you have a bleeding problem or a bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Have you ever been hospitalized for any illness or operations? Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any of the following? Please Check

☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Lung Disease	☐ Sleep Apnea
☐ Angina	☐ Emphysema	☐ Lupus	☐ Steroid Therapy
☐ Anemia	☐ Epilepsy or Seizures	☐ Migraine	☐ Stomach Ulcers
☐ Arthritis	☐ Fibromyalgia	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Cancer	☐ Heart Attack	☐ Pacemaker	☐ Thyroid Disorder
☐ Chest Pain	☐ Heart Murmur	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 1	☐ Hodgkins Disease	☐ Rheumatic Fever	
☐ Diabetes Type 2	☐ Hypo/Hyperglycemia	☐ Sexually Transmitted Infection	
☐ Digestive Disorders / Acid Reflux	☐ Kidney Disease	☐ Shortness of Breath	

Are there any conditions or disease not listed above that you have or have had? Yes ☐ No ☐ Not Sure ☐

If yes, please list ______

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Do you smoke or chew tobacco products? Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment? Yes ☐ No ☐ Not Sure ☐

If yes, please explain ______

Are you pregnant ? Yes ☐ No ☐ Not Sure ☐

______

______

Hygienist ______________________ **Tel** ______________________

Address ______________________

The Information I have given above is true to the best of my knowledge

Patient Signature ______________________ **Date** ______________