www.powisstreetdentalpractice.comhello@smilewithpridedentalcare.co.uk020 8854 0726

SMILE WITH PRIDE DENTAL CARE

CONFIDENTIAL MEDICAL HEALTH QUESTIONNAIRE

Please fill in accurately and in full. Ask if you are not sure of anything.

Mr/Mast/Mrs/Miss/Ms/ Other	Click or tap here to enter text.
Patient's Full Name	Click or tap here to enter text.
Date of Birth	Click or tap here to enter text.
Address	Click or tap here to enter text.
Postcode	Click or tap here to enter text.

Occupation		Click or tap here to enter text.
Tel:	Home	Click or tap here to enter text.
	Mobile	Click or tap here to enter text.
	Email Address	Click or tap here to enter text.

GP's Name	Click or tap here to enter text.
Practice Address	Click or tap here to enter text.
Post Code	Click or tap here to enter text.
Telephone No	Click or tap here to enter text.

COVID-19 SCREENING – IN THE LAST 14 DAYS HAVE YOU EXPERIENCED

- SHORTNESS OF BREATH OR COUGHYES/NO
- FEVERYES/NO
- LOSS OF TASTE OR SMELLYES/NO
- BEEN IN CONTACT WITH SOMEONE WITH COVID-19 SYMPTOMS YES/NO

ARE YOU:

1. Attending or receiving treatment from a doctor, hospital or specialist at present?YES/NO
2. Undergoing or awaiting results of any health investigations? (Please specify overleaf)YES/NO
3. Taking any medicines from your doctor? (List them in the space provided overleaf)YES/NO
4. Taking or have taken any form of steroids in the last two years?YES/NO
5. Taking any medications for Osteoporosis? (Soft or Brittle bones)YES/NO
6. Allergic to any specific medicines, food or materials? (Please specify overleaf)YES/NO

HAVE YOU:

1. Had Kidney disease or Hepatitis A, B or C?YES/NO
2. Had any heart problems such as Blood Pressure, Angina, Heart Murmur?YES/NO
3. Had any heart surgery e.g. Bypass, Replacement valves or a Pacemaker?YES/NO
4. Possibly been exposed to or tested for HIV, TB, CJD?YES/NO
5. Had a bad reaction to a General or Local anaesthetic?YES/NO

DO YOU:

1. Have Arthritis or replacement Joints?YES/NO
2. Suffer from Hay Fever, Bronchitis or Asthma or any other allergy?YES/NO
3. Have Epilepsy, Parkinson's disease or MS?YES/NO
4. Have Diabetes or Thyroid problems?YES/NO
5. Bruise easily or bleed excessively to cause worry?YES/NO
6. Carry any warning cards for any reason? (Please specify overleaf)YES/NO
7. ARE YOU NOW OR COULD YOU BE PREGNANT?YES/NO/POSSIBLY
8. Have you any other medical problems that we should know about?YES/NO
   Please specify them here. Mention them even if you are not sure that we might need to know.

   Click or tap here to enter text.

I consent to the above information being shared with other health care professionals in relation to my care and for the practice to keep me informed about advances in dental health care.

Completed by: Patient/ Parent/ Guardian Signature Click or tap here to enter text. Date Click or tap here to enter text.

Date Updated (Dentist) (1)…… (2)…… (3)…… (4)……

Knowing more about you and your concerns

1. When was the last time you had to have any dental treatment (not including simple check-ups)?

Less than 1 year ago ☐ 1-2 years ago☐ 3-5 years ago☐ 5 years +☐ Don't remember☐

2. How did you find this practice:

Google☐ Internet searches☐ Passing by☐ Recommended☐ Other☐

3. Have you left another practice in order to come here?Yes/No

If you think it is important to tell us why, please do so here. Click or tap here to enter text.

4. Are you concerned about any aspect of your dental health at the moment?Yes/No
5. Are you happy with your smile and the appearance of your teeth?Yes/No
6. How well do you think you do at Brushing and Flossing to keep your teeth clean?

Very well☐ Quite well☐ Could do better☐ Not very well☐ Don't Know☐

7. How well do you think you control your diet in terms of daily sugary food/drink intake?

Very well☐ Quite well☐ Could do better☐ Not very well☐ Don't Know☐

Would you like a Dietary analysis to try identify how your diet could improve to help control your tooth decay experience?
Yes☐ Not sure☐ No☐

8. Do you currently smoke or use any form of Tobacco, incl e-cigarettes, or chew Paan or Betel nut?

Yes☐ No☐

For how many years? 1-2 years☐ 3-5 years☐ 6-9 years☐ 10 years☐

How many times every day? 5-10 a day☐ 10-20 a day☐ 20-30 a day☐ 30+ a day ☐

Apart from the well-known serious effects on your general health, are you aware that smoking can have a major impact on your Oral Health? Yes/No

Would you be interested in a referral to a Free NHS 'STOP SMOKING' Programme? Yes/No

9. Do you drink Alcohol? Yes☐ No☐

For how many years? 1-2 years☐ 3-5 years☐ 6-9 years☐ 10 years+☐

How many units do you drink? 1-5 a week☐ 5-10 a week☐ 10-20 a week☐ 20+ a week ☐

1 unit of alcohol is 1/2 pint of normal larger, one small glass of wine or a single unit of spirits.

10. Would you like to discuss any of the following with the dentist

1. Diet control and Decay
2. Gum Problems/Bad Breath
3. Tooth Coloured Fillings
4. Bleaching/Whitening
5. Adult Orthodontics/Invisible Braces
6. Cosmetic Procedures

11. Please list your current medications or allergies here. (We can copy your prescription if you have it on you.)

1. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.
7. Click or tap here to enter text.

Thank you for your cooperation in the completion of this form.