park • avenue
dental • care

Medical Health Questionnaire

If you are a new patient at park avenue dental care, may we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. So that we can do our best for you, we would like to ask you a few questions which will take about five minutes to answer.

Please tell us:

Your full name .....

Address .....

.....

.....

Postcode .....

Daytime number .....

Evening number .....

Mobile number .....

Email .....

Date of birth .....

NHS number .....

Occupation .....

Doctor's name .....

Doctor's address .....

.....

.....

For use in case of emergency:

Next of Kin

Name .....

Tel .....

When did you last visit a dentist ?

.....

Which of the following statements best describes your feelings about visiting the dentist ? Tick the one you agree with.

□ I feel relaxed

□ I feel a little anxious

□ I feel very anxious and nervous

Are there any dental procedures which have frightened you in the past, or which you are very anxious about ?

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Have you left another practice in order to come here ?

□ Yes □ No

If you think it is important to explain why, please do so.

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A. ARE YOU

If yes — please give details

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist ? Yes/No.....
   .....
2. Taking any medicines or tablets prescribed your doctor ? Yes/No.....
   .....
3. Allergic to penicillin or any other drug or substance ? Yes/No.....
4. Pregnant or likely to be so ? Yes/No.....

B. HAVE YOU

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke ? Yes/No.....
   .....
2. Ever had rheumatic fever ? Yes/No.....
3. Ever had jaundice, hepatitis, liver problems or kidney disease ? Yes/No.....
4. Ever had asthma, eczema, bronchitis or any serious chest infections ? Yes/No.....
5. Ever had any blood tests or blood related diseases ? e.g. HIV or Hepatitis Yes/No.....
6. Ever had a bad reaction to a local or general anaesthetic ? Yes/No.....
7. Ever had an operation or received hospital treatment ? Yes/No.....
8. Ever had a heart valve replaced ? Yes/No.....
9. Ever been diagnosed as having CJD? (or has any member of your family) Yes/No.....
10. Ever had a stomach ulcer ? Yes/No.....

C. DO YOU

1. Have a pacemaker or any form of heart surgery ? Yes/No.....

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2. Have fainting attacks, giddiness or epilepsy ? Yes/No.....
3. Have diabetes or does anyone in your family ? Yes/No.....
4. Have regular headaches ? Yes/No.....
5. Carry a warning card ? Yes/No.....
6. Bruise easily or have you ever bled excessively ? Yes/No.....
7. Take or have you ever taken steroids ? Yes/No.....
8. Do you smoke ? If so, how much Yes/No.....
9. Do you drink ? If so, how much Yes/No.....

We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us. Were any of the following reasons involved ?

- □ Convenient location
- □ I was recommended by a friend
- □ Convenient surgery hours
- □ Family member already a patient here
- □ For emergency treatment only
- □ Referred by another dentist
- □ Located from Yellow Pages
- □ Located from our website
- □ Another reason, please specify

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Thank you for taking the time to answer our questions

Personal dental assessment	**Yes**	**No**
1. Are you satisfied with your teeth and their appearance ?	□	□
2. Are you self conscious about your teeth when you smile ?	□	□
3. Do you wish your teeth were whiter ?	□	□
4. Do you have any discoloured teeth or fillings which embarrass you ?	□	□
5. Do you wish the fillings in your back teeth were tooth coloured instead of black ?	□	□
6. Do your gums bleed when you brush your teeth ?	□	□
7. Do you suffer from bad breath—halitosis ?	□	□
8. Do you have any gaps/ or missing teeth that concern you ?	□	□
9. Can you eat comfortably ?	□	□
10. Do you have regular headaches ?	□	□

11. If you could alter your smile what would you must like to change ? Is there anything else you would like to tell us about your teeth ?

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Patient's Signature ..... Date .....

Dentist's Signature ..... Date .....

Date	No Change	List any changes	Patient initials	Dentist initials