

BOURNE HALL DENTAL PRACTICE

This provides the dentist with important information required for your Dental Treatment and Oral Health Care.

Name: _____
Date of Birth: _____
Home Address: _____
Post Code: _____
Home Phone: _____
Occupation: _____
Email: _____
Details of Person to Contact in an Emergency:
Name: _____
Medical Doctors Name: _____

First Names _____ Surname _____ Dr / Mr / Mrs / Miss / Ms / Mst
/ / /
Work Address: _____
Work Phone: _____
Mobile Phone: _____
Fax: _____
Phone Number: _____
Phone Number: _____

MEDICAL HISTORY

1. Have you ever had any of the following? If so, tick as appropriate.
- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Rheumatic Fever or Chorea | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gastric Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Chest Problems | <input type="checkbox"/> Bells Palsy |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Depressive Illness | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Drug Dependence |
- Hepatitis – (specify type A, B, C) or jaundice?
2. Are you receiving any medical treatment at the present time? Yes/No
Details: _____
3. Have you been a patient in hospital during the last two years? Yes/No
Details: _____
4. Have you taken any medicines, tablets, capsules or drugs during the last two years? Yes/No
Details: _____
5. Have you had allergies/unusual effects from any tablets, drugs, injections or anaesthetics? Yes/No
Details: _____
6. Are you, or have you been under the care of a doctor during the past two years? Yes/No
Details: _____
7. Have you or a close family member been diagnosed with CJD or similar prion disease? Yes/No
Details: _____
8. Are you a smoker? Yes/No
9. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes/No
Details: _____
10. If female are you pregnant? If so, how many months? _____ Yes/No
11. Do you have any blood-born diseases? Yes/No
12. Do you have dental treatment under sedation? Yes/No
13. Do you suffer from Faints or Dizziness? Yes/No

DENTAL HISTORY

1. Name of last Dentist: _____
2. Approximate date of last dental visit: _____
3. Do you have Dental Pain or a Dental Problem at Present Yes/No
Details: _____
4. Have you had excessive bleeding or bruising from dental treatment, cuts or scratches? Yes/No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes/No
6. Are there aspects of your dental health/appearance that you are unhappy with and would like to change? Yes/No
- REFERRED BY: Yellow Pages Another Patient/Friend (Name) _____
 Street Sign Other (please specify) _____
- Signed: Patient/Parent/Guardian: _____ Date: _____