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THE **COSMETIC DENTAL** STUDIO

WWW.THECOSMETICDENTALSTUDIO.COM

CONFIDENTIAL HEALTH QUESTIONNAIRE

To obtain the best and safest treatment, your dentist needs to know of any medical problems that may affect your dental treatment. Please delete as applicable.

Title .... **First Name** .... **Surname** .... **Sex** .... **Age** ....

Date of Birth .... **Occupation**... **Address**...

.... **Postcode** ....

Telephone No .... **Mobile No** .... **Doctor**..

Please read the questions below and give us more information if they apply to you:

Are You:

1. Attending or receiving treatment from a doctor? ....
2. Taking or using any medicine, pills, tablets, inhalers, ointments, injection or any other drug? ....
3. Taking or have been taking steroids in the last two years? ....
4. Allergic to or had any bad reaction to medicines, antibiotics, foods or other substances? ....
5. Are you on medication for Osteoporosis or Cancer?..
6. Are you a smoker?...

Have You:

1. Had rheumatic fever or chorea (St Vitus's Dance)? ....
2. Had jaundice liver, kidney disease or hepatitis? ....
3. Ever been told you have a heart murmur/attack/problem/angina/blood pressure? ....
4 Had any blood tests, inoculations, etc?...
5. Had your blood refused by the Blood Transfusion Service? ....
6. Had a bad reaction to a general or local anaesthetic? ....
7. Had a joint replacement? ....
8. Ever been hospitalised? ....

Do You:

1. Have arthritis?...
2. Have a pacemaker or have you had any form of heart surgery?..
3. Suffer from hay fever, eczema, asthma or any other allergy?...
4. Suffer from bronchitis, asthma or other chest condition?...
5. Have fainting attacks, giddiness, blackouts or epilepsy? ....
6. Have diabetes or does anyone in your family? ....
7. Bruise easily or following extraction, surgery or injury, bleed to excess? ....
8. Carry a warning card? ....
9. Ever get cold sores?...
10. Are there any other aspects concerning you health that you think the dentist should know about? ....

Completed by: Self/Parent/Guardian:

Signature:... **Date:** ....

Dentists Signature:... **Date:** ....

(Please turn over)

HARWICH
49 Kingsway, Dovercourt,
Harwich, Essex, CO12 3JT
tel: 01255 508570

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25 Carnarvon Road,
Clacton-on-sea, Essex, CO15 6QF
tel: 01255 423299

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HOW CAN WE HELP YOU?

To help us plan the best possbiel care for you, both now and in the future, it will greatly assist us if we know a little about your prevous dental experiences and your hopes and aims for the future.

PLEASE ANSWER THE FOLLOWING QUESTIONS:-

1. How do you feel about your teeth and their appearance?

....

....

....

2. What is your main concern for your teeth?

....

....

....

3. Is there anything you would like us to know about your previous dental experiences?

....

....

....

4. What are your hopes and aims for your mouth?

....

....

....

5. How would you describe your diet? Poor .... Average .... Good .... Excellent ....

6. Do you take any sugar in beverages? Yes .... No ....

7. How often do you clean your teeth? ....

8. Do you smoke? Yes .... No.......... If yes, how many per day? ....

9. Is there anything else you would like us to know?

....

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