Medical History

Name. _____ Date of Birth. _____/_____/

Do you have any dental pain or problems? If yes, briefly explain. _____ _____	Yes	No
Do you have frequent headaches?	Yes	No
Do you suffer from a dry mouth?	Yes	No
Have you been in hospital in the past 12 mths? If so specify. _____	Yes	No
Do you want to keep the teeth you have?	Yes	No

What do you use to clean your teeth (Please circle any of the following)

Toothbrush	Floss/Dental Tape	Toothpicks/Sticks
Electric Toothbrush	Interdental Brush	Mouth Rinse

How long since you visited a dentist? (circle one of the following).

Less than six months	Six to twelve months	1-2 years	If more specify _____

How would you rate your mouth at the moment? (Circle One)

Fair	Good	Excellent

Medications-What Drugs or Supplements Are You Taking?

Name	Reason	Quantity

Do you/have you had any of the following? Circle answer.

Cancer (Type_____)	**Yes**	**No**
Chemotherapy/Radiation Treatment.	**Yes**	**No**
Are you pregnant? If so please specify how many weeks: _____	**Yes**	**No**
Immune deficiencies	**Yes**	**No**
Liver Disease	**Yes**	**No**
Do you smoke.	**Yes**	**No**
Do you drink alcohol	**Yes**	**No**
Have you ever been advised to take prophylactic antibiotics prior to dental treatment.	**Yes**	**No**

Name of your local doctor _____

Heart Problems (e.g. pacemaker, murmur, angina, valve surgery , heart attack, bypass).	Yes	No
Lung Problems (asthma, TB, emphysema etc).	Yes	No
Kidney Disease.	Yes	No
Allergies (specify) _____ _____	Yes	No
Rheumatic Fever.	Yes	No
Joint Replacement surgery/problems.	Yes	No
Stroke.	Yes	No
Fainting/Seizures (epilepsy etc).	Yes	No
Hepatitis (A,B,C,D,E).	Yes	No
Arthritis	Yes	No
Excessive Bleeding/blood disorders.	Yes	No
Stomach Problems.	Yes	No
Thyroid Problems.	Yes	No
High/Low Blood Pressure.	Yes	No
HIV/AIDS.	Yes	No
Herpes.	Yes	No
Neck/Back Problems.	Yes	No
Diabetes	Yes	No
Other? Please specify. _____ _____ _____		

Please number in order of their priority to you. For example if you viewed function as your highest priority, longevity next, followed by cost, cosmetics & then your comfort, your numbering would follow the sequence set out in the grey example below.

Function (Able to eat and speak properly).	1	
Cosmetics (Able to smile with confidence and look good).	4	
Cost (Your treatment should fit into your budget)	3	
Longevity (Your treatment should give you long-term peace of mind).	2	
Comfort (During and after treatment).	5	

Signed. _____

Date. _____/_____/_____

Signed. _____

Date. _____/_____/_____

Signed. _____

Date. _____/_____/_____

Signed. _____

Date. _____/_____/_____