NDP - Natureza Dental Practice
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PATIENT INFORMATION & MEDICAL HISTORY

Name: _____

Address: _____

_____ Postcode: _____

Telephone: _____ Mobile: _____

Email: _____ Date of Birth: _____

GP Name / Address: _____

_____

In the event of an emergency, please contact:

Name: _____

Tel No: _____ Relationship to you: _____

Smile Check

Please answer yes or no to help us know your current dental concerns and bring this form with you to your appointment.
LET US HELP YOU TO IMPROVE YOUR MOUTH AND SMILE.

- Would you like your teeth to look whiter or brighter? ..... Yes / No
- Are your teeth sensitive? .....Yes / No
- Have you any teeth you think are unsightly, misshapen or out of line? ..... Yes / No
- Do you have any old crowns that now do not match your other teeth or have dark lines at the gums? ..... Yes / No
- Do you have old or stained fillings that show when you smile? ..... Yes / No
- Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better? ..... Yes / No
- Do you have any missing teeth that you would like replacing to improve your smile and your bite? Do you have an old, worn denture, or an NHS denture that looks false and feels false? ..... Yes / No
- Are your teeth stained or your gums red and swollen? ..... Yes / No
- Do your gums bleed when brushing? ..... Yes / No
- Do you get a bad taste in your mouth or around some teeth? ..... Yes / No
- Are you concerned that you may have bad breath? ..... Yes / No
- Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite? ..... Yes / No

Have you ever had the following?

1. Hospital treatment for illness or injury..... Yes / No

Please Specify _____

2. Are you taking any prescribed medicines? ..... Yes / No

Please Specify _____

3. Are you carrying a medical warning card? ..... Yes / No

4. Do you have any allergies to medicines (e.g. Penicillin), substances (e.g. Latex, local anesthetic) or foods?.. Yes / No

Please Specify

_____

5. Heart problems, angina, blood pressure problems or stroke ..... Yes / No

6. Rheumatic fever ..... Yes / No

7. Bruising or prolonged bleeding following injury, tooth extraction or surgery ..... Yes / No

8. Bronchitis, Asthma or other chest condition ..... Yes / No

9. Sinus problems ..... Yes / No

10. Kidney or liver disease ..... Yes / No

11. Hormone deficiency i.e. thyroid..... Yes / No

Please specify _____

12. Diabetes ..... Yes / No

13. Digestive disorders..... Yes / No

14. Arthritis ..... Yes / No

15. Glaucoma ..... Yes / No

16. Osteoporosis..... Yes / No

17. Fainting attacks, giddiness, blackouts, epilepsy or convulsions ..... Yes / No

18. Cold sores ..... Yes / No

19. Hay fever..... Yes / No

20. Hepatitis (type_____) / HIV ..... Yes / No

21. Radiation therapy..... Yes / No

22. Chemotherapy ..... Yes / No

23. Psychiatric treatment..... Yes / No

24. Any other serious illness or infectious disease ..... Yes / No

Please Specify _____

Are you

25. Presently being treated for any Other illness ..... Yes / No

26. A smoker or smoked previously ..... Yes / No

If yes, how many cigarettes per day? _____

27. Do you drink alcohol? ..... Yes / No

If yes, how many units per week (1 unit = half a pint of lager, a single measure of spirits or a single measure of wine/aperitif) _____

28. Female – Pregnant..... Yes / No

29. Male – Prostate disorders ..... Yes / No

Dental History:

How would you rate the condition of your mouth? ..... Excellent / Good / Fair / Poor

What is your immediate concern? _____

Please answer yes or no to the following:

Personal History

1. Are you fearful of dental treatment?..... Yes / No
2. Have you ever had an unfavourable dental experience?..... Yes / No
3. Have you ever had complications from past dental treatment?..... Yes / No
4. Have you ever had trouble getting numb or reactions to local anaesthetic? ..... Yes / No
5. Did you ever have braces, orthodontic treatment or had you bite adjusted?..... Yes / No
6. Have you ever had teeth removed? ..... Yes / No

Bite and Jaw Joint

7. Do you / would you have any problems chewing gum? ..... Yes / No
8. Have your teeth changed in the past 5 years, become shorter, thinner or worn?..... Yes / No
9. Are your teeth crowding or developing spaces? ..... Yes / No
10. Do you have more than one bite or do you clench (squeeze) to make your teeth f it together? ..... Yes / No
11. Do you have problems with sleep or wake up with an awareness of your teeth?..... Yes / No
12. Do you have any problems with your jaw joint (pain, sound, limited opening, locking, popping etc.)? ..... Yes / No
13. Do you have tension headaches or sore teeth?..... Yes / No
14. Do you wear or have you ever worn a bite appliance? ..... Yes / No

Tooth Structure

15. Have you had any cavities within the past three years?..... Yes / No
16. Do you have a dry mouth?..... Yes / No
17. Are any teeth sensitive to hot, cold, biting or sweets? ..... Yes / No
18. Have you ever had a toothache, cracked f illings, broken, Chipped or cracked teeth? ..... Yes / No
19. Do you avoid brushing any part of your mouth? ..... Yes / No

Gum and Bone

20. Have you ever been diagnosed or treated for periodontal (gum) disease? ..... Yes / No
21. Have you ever experienced gum recession?..... Yes / No
22. Is there anyone with a history of periodontal disease in your family? ..... Yes / No
23. Are your teeth becoming loose?..... Yes / No
24. Do your gums bleed when brushing, f lossing or eating? ..... Yes / No
25. Have you noticed an unpleasant taste in your mouth? ..... Yes / No
26. Have you ever experienced a burning sensation in your mouth?..... Yes / No

Patient Signature: _____ Date: _____