Confidential Updated Medical History

Name of patient (in CAPITALS) _____ **Date:** __ /__/ __

	YES	NO	Further Details
Are You			
Attending or receiving treatment from a doctor, hospital, clinic or specialist			
Taking any tablets or medicines prescribed by your GP or bought over the counter			
Pregnant or nursing mother			
Do you suffer from any allergies e.g.-Penicillin ,Aspirin, foods			
Taking or have taken steroids in the last 2 years.			
Have You			
Had any serious illness or operation in the last 3 years			
Had Rheumatic fever, Chorea or St Vitus dance			
Ever had Jaundice, Liver or kidney disease or hepatitis			
Had heart troubles e.g. murmurs, birth defects, angina, hypertension			
Ever had a reaction to Local or general Anaesthetic			
Please inform the dentist if you are HIV positive or have had blood refused from the blood transfusion service			
Do You/Does Your			
Suffer from headaches/Migraines			
Clench and /or grind your teeth or have a jaw click			
Suffer from fainting spells, blackouts, epilepsy , breathlessness or chest pains			
Have abnormal blood pressure high or low			
Suffer from Diabetes			
Bruise easily or have you ever bled excessively			
Have any stomach problems			
Have any medical prosthesis, hip replacement, artificial heart valve, pacemaker			
Do you Smoke? If so how many a day			
Do you drink alcohol on a regular basis? If so how many units per week?			

We are looking for patients to join our focus group. If you wish to participate please inform our receptionist. Many Thanks

Patient/Parent Signature: .....…..***Email Address***……

Dentist Signature:.....**Date:**..... P.T.O

Gum Disease Risk Assessment

Gum disease will affect almost everyone at some stage in their life. This short questionnaire can help us find the best way to help you prevent this.

Please circle all answers that apply

RISK FACTORS	AT RISK	LOW RISK
Do you smoke?	YES	NO
Are you diabetic?	YES	NO
Are you on any medication?	YES	NO
Do you suffer with stress?	YES	NO
Are you pregnant?	YES	NO
Is there a family history of gum disease?	YES	NO

Do your gums bleed when brushing? .....

Do you have red gums, rather than the usual pink colour? .....

Do you have puffy or swollen gums? .....

FOR DENTIST USE

	NO RISK	LOW RISK	MODERATE RISK	HIGH RISK
Risk factors(any of the list)	NO	YES	YES	YES
Gingivitis	NO	YES or NO	YES	YES
Periodontal disease early or moderate	NO	NO	YES or NO	YES
Periodontal disease severe/advanced	NO	NO	NO	YES or NO

Proposed treatment plan:			
Smoking Cessation Advice Given	YES	NO	N/A