DENTALMENU

LET US HELP YOU TO IMPROVE YOUR MOUTH AND SMILE

Please tick the relevant boxes to help us know your current dental concerns

- [ ] Would you like your teeth to look whiter or brighter?
- [ ] Are your teeth sensitive?
- [ ] Have you any teeth you think are unsightly, mis-shapen or out of line?
- [ ] Do you have any old crowns that now do not match your other teeth or have dark lines at the gums?
- [ ] Do you have any old or stained fillings that show when you smile?
- [ ] Do you have any silver fillings that you would like replacing with tooth coloured mercury free restorations so that they blend in better?
- [ ] 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?
- [ ] Are your teeth stained or your gums red and swollen?
- [ ] Do your gums bleed when brushing?
- [ ] Do you get a bad taste in your mouth or around some teeth?
- [ ] Are you concerned that you may have bad breath?
- [ ] Do you play contact sports without wearing a gum shield to protect your teeth, smile and your bite?

Date........................... Date........................... Date........................... Date........................... Date...........................

Signature..................... Signature..................... Signature..................... Signature..................... Signature.....................

laburnum
DENTALPRACTICE

medical & dental history

96 Laburnum Avenue · Wallsend · Tyne & Wear · NE28 8HG
Tel: 0191 262 4079 Fax: 0191 263 7150
Email: mail@laburnumdentalpractice.co.uk

www.laburnumdentalpractice.co.uk

CONFIDENTIAL MEDICAL HISTORY

Title .... Full Name ....

Date of Birth ....

Address ....

.... Postcode...................................

Home Tel No .... Daytime number ....

Occupation ....

Name and address of your doctor ....

....

....

Expectant mother yes ❑ no ❑

How did you hear about the practice? Friend/family ❑ Yellow pages ❑ Flyer ❑ Other ❑

Are you:	**Circle**	**Details**
Attending/receiving treatment from doctor or hospital?	Yes/No	....
Taking medicines from your doctor (tablets, creams etc)?	Yes/No	....
Taking or have taken steroids in the last two years?	Yes/No	....
Allergic to any foods, materials or drugs?	Yes/No	....

Have you:	**Circle**	**Details**
Had rheumatic fever?	Yes/No	....
Had jaundice, liver, kidney disease?	Yes/No	....
Ever been told you had a heart murmur, heart problems, angina or high blood pressure?	Yes/No	....
Had a blood tests, inoculations etc?	Yes/No	....
Ever had blood refused by the blood transfusion service?	Yes/No	....
Had a bad reaction to local or general anaesthetic?	Yes/No	....
Had a joint replacement?	Yes/No	....
Been hospitalised?	Yes/No	....
Any disabilities that we should know of?	Yes/No	....

Do you:		
Have arthritis?	Yes/No	....
Have a pacemaker or had heart surgery?	Yes/No	....
Suffer from bronchitis or asthma?	Yes/No	....
Have fainting attacks, blackouts or epilepsy?	Yes/No	....
Have diabetes?	Yes/No	....
Carry a warning card?	Yes/No	....
Bruise easily or following extraction or injury bleed so as to cause concern?	Yes/No	....
Suffer from headaches or migraines?	Yes/No	....
Smoke or did in the past? If yes how many per day?	Yes/No	....
Do you drink > 20 units of alcohol a week. How many? 1 unit = 1/2 pint lager, 1 small glass wine, 1 measure spirits)	Yes/No	....
Have any infectious diseases? (including hepatitis and HIV)	Yes/No	....
Have you had brain surgery, growth hormone treatment or do you or a close relative have Creutzfeldt Jakob Disease?	Yes/No	....
Have there been any changes in your medical history since your last course of treatment?	Yes/No	....

Signed .... **Date** ....