

welcome



the terrace dental practice

Smile, you're in good hands[©]

The Terrace Dental Practice
61-63 Church Street, Padiham,
Lancashire BB12 8JH

Surname (Mr/Mrs/Miss/Ms) _____

First Name _____

Address _____

Postcode _____ Occupation _____

Date of Birth _____ Home Tel No _____

Work Tel No _____ Mobile Tel No _____

Your Doctor's name & address _____

Date of last dental treatment

Day	Month	Year
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Certain medical conditions can affect dental treatment and vice versa

Please complete all sections of this questionnaire

Are you:

	yes	no
Pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
Carrying a warning card? _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking ANY medication (tablets, medicine, injections, inhalers)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Having treatment from a doctor, hospital or clinic? _____	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had:

a general anaesthetic for ANY reason? _____	<input type="checkbox"/>	<input type="checkbox"/>
a bad reaction to general or local anaesthetic? _____	<input type="checkbox"/>	<input type="checkbox"/>
treatment with hydro-cortisone or corticosteroids? _____	<input type="checkbox"/>	<input type="checkbox"/>
a joint replacement operation? _____	<input type="checkbox"/>	<input type="checkbox"/>
a blood donation refused? _____	<input type="checkbox"/>	<input type="checkbox"/>
a blood test or sickle cell test? _____	<input type="checkbox"/>	<input type="checkbox"/>
a close relative with Creutzfeldt Jakob Disease? (parent, sibling, child, grandparent or grandchild) _____	<input type="checkbox"/>	<input type="checkbox"/>
Any infectious diseases (including HIV or hepatitis)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth hormone treatment before the mid 1980's _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you ever suffered from:

Rheumatic fever? _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition, heart murmur, high blood pressure or stroke? _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, fits or convulsions? _____	<input type="checkbox"/>	<input type="checkbox"/>
TB, bronchitis, asthma or other chest problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice, liver or kidney problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding, excessive bruising or anemia? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever or Eczema? _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to ANY medicine s(e.g. antibiotics), substances (e.g. latex), or foods? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness? _____	<input type="checkbox"/>	<input type="checkbox"/>

How many units of alcohol do you drink per week? (1 unit = half pint of lager/singe measure of spirit)

If you smoke, how many a day?

Are you nervous when visiting the dentist? Please place a mark on the scale. 1=very relaxed. 10=very nervous.

1-----5-----10

Please give any other details which your dentist might need to know about _____

Completed by: Patient/Parent/Guardian

Signature:	Date:
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Please be aware that you are not a patient of the practice until you attend your initial examination