Medical Status

Name:

Date of Birth:

Address:

Mobile:

Phone Number:

Email Address:

Are you happy to receive information from the practice via email or Text **Y/N**

Are you happy with your teeth **Y/N**

If No, what are you not happy with or would like to change?……
……
……
Do you have dentures **Y/N** if yes: how old are they ? ……..years. Are you happy with the fit? **Y/N**

Do you have you any Heart Problems?

- Have you had rheumatic fever or chorea (St Vitus Dance)? **Y/N**
- Have you ever had a heart attack or stroke? **Y/N**
- Have you had any form of heart surgery? Or endocarditis? **Y/N**
- Do you have a pacemaker? **Y/N**
- Have you ever been told you have a heart murmur **Y/N**
- Do you have or ever suffered with angina? **Y/N**
- Do you have any other heart problem or valve replacement? **Y/N**

If yes details are…….

Do you have any chest problems?

- Do you suffer from bronchitis? **Y/N**
- Have you ever had chest surgery **Y/N**
- Do you suffer from Asthma? **Y/N**
- Do you suffer from any other chest condition? **Y/N**

Any Problems with your Blood?

- Have you ever had your blood refused by the Blood Transfusion Service? **Y/N**
- Do you bruise easily **Y/N**
- Following a tooth extraction, surgery or injury have you or your family bleed so to cause you to be worried? **Y/N**
- Do you suffer with Hepatitis, HIV or vCJD? **Y/N**
- Are you undergoing any Blood tests? **Y/N**

Do you have any other conditions?

- Any serious childhood illness ……. **Y/N**
- Do you suffer with liver disease? **Y/N**
- Do you suffer with kidney disease? **Y/N**
- Have you ever had Cancer?..... **Y/N**
- Do you have fainting attacks, giddiness, black outs or epilepsy? **Y/N**
- Have you ever had jaundice, **Y/N**
- Are you taking or have you taken steroids in the last 2 years? **Y/N**
- Are you pregnant? **Y/N**
- Any Other Conditions …….. **Y/N**

Do you have any Allergies to any medicines, foods or materials?

- Do you suffer from hay fever **Y/N**
- Do you suffer from eczema **Y/N**
- Do you have any other allergy? **Y/N**
- Have you had any blood tests, inoculations etc.? **Y/N**
- Have you had a bad reaction to a general or local anaesthetic? **Y/N**
- Have you had a joint replacement? **Y/N**
- Have you been hospitalised? If "Yes" what for and when? **Y/N**
- Do you carry a warning card? **Y/N**

- Are there any other aspects concerning your health that you think your dentist should know about? **Y/N**

- Are attending or receiving treatment from your doctor? **Y/N**

- Are you taking any medicines from your doctor? **Y/N**
  (E.g. Tablets, creams, ointments, injections, inhalers, including contraceptives and hormone replacement therapy)

  Please list below:

  Your Dr's Name ……
  Address……
  ……

Periodontal Risk Assessment Questionnaire

Tobacco Use: This is the most significant risk factor for gum disease

Please circle if you ***now*** or ***have ever*** used

Cigarettes Cigars Pipe Chewing Tobacco/Paan Snuff

Amount Per day Used for How many Years If you quit, when did you quit?

_____ _____ _____

Heart Attack/Stroke: Untreated gum disease can increase your risk of heart attack or stroke

Do you have any other risk factors for heart disease or stroke? (please circle) None

Family history of heart disease Tobacco Use High Cholesterol High Blood Pressure

Medications: A side effect of some medications causes changes in gums

Have you ever taken the following medications?

None Anti-Epileptic Medications Calcium Channel Inhibitors Cyclosporin

Genetic: The tendency for gum disease to develop can be inherited

Has anyone on your side of the family had gum problems (eg mother, father or siblings)?

Yes No

Diabetes: Diabetics are more prone to gum disease. If left untreated, gum disease makes it harder to control their blood sugar. When gum disease is eliminated, diabetics may improve their blood sugar control and make diabetic complications less likely.

Any family history of diabetes? Yes No

Have you had any of these warning signs of diabetes? None

Frequent urination Excessive thirst Excessive hunger

Weakness and fatigue Slow healing of cuts Unexplained weight loss

Rheumatoid Arthiritis: The causes of gum disease and RA may be related. One doesn't cause the other, but when one is present the other is more likely to be going on. If your gums are inflamed you may be at increased risk for developing RA.

Have you ever been diagnosed with Rheumatoid Arthritis? Yes No

If you have rheumatoid arthritis, emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis

Special Concerns for Females:

Pregnancy: Tell us if you are planning to become pregnant. Gum disease can make it up to eight times more likely that you will have a pre-term low birth weight baby. You can greatly reduce the likelihood of having an adverse pregnancy outcome by finding out if you have any gum disease and then doing whatever is necessary to eliminate it before you get pregnant. It is also important to make sure your gums are inflammation free while you are pregnant.

Osteoporosis:

Do you have osteoporosis? Yes No

The following are risk factors for osteoporosis: *Post-menopausal, Family history of osteoporosis, Early menopause, Rheumatoid Arthritis, Inadequate exercise, Smoking*

Do you have any risk factors for osteoporosis? Yes No

Have you ever been tested? Yes No

Please tick or fill-in the correct responses to the following:

Do you drink alcohol? Yes No Never

Approx. units per week ☐
(1 unit=glass wine, half pint, 1 shot)

Are you a regular attendee at the dentist? Yes No

How long since you last attended the dentist? 6 months 1 year 5 years Longer

Do you have any of the following problems or symptoms at present? Please tick:

Change in voice (hoarseness) ☐

Bleeding (mouth, nose, ear) ☐

Earache Sore throat ☐

Lump in neck ☐

Difficulty swallowing ☐

Sore or ulcer in mouth ☐

Tooth or gum problem ☐

Red or white patch in mouth ☐

Has anyone in your family been treated for cancer of the Mouth, Head and Neck?
Yes No Site of cancer ☐

Consent to Mouth Cancer Screening
I consent to this mouth cancer screening and understand that this screening is not intended to be a complete head and neck examination. In the event of an abnormality being detected, I will be responsible for any follow-up examination, diagnostic test or treatment required. The results of this examination and information on this form may be used for research purposes. My name will not be released to any other person or organisation without my express written consent.

Signature: ..... **Date.....**

I have read my medical status form and confirm that there are no changes

Name	Signed	Date	Dentist Initials

My Last visit to my GP was ……..

I wish to make the following Changes to My medical status:

Medications: