Cambridge Dental Hub

Love Your Smile 1 Brooke House, Kingsley Walk, Newmarket Road, Cambridge, CB5 8TJ Love Your Smile

01223 363277 reception@cambridgedentalcare.co.uk www.cambridgedentalhub.co.uk

Dr David Gilmartin, Dr Jaime De Castro Torres, Dr Monica Cueva Moya, Dr I-Chun (Mago) Peng, Dental Surgeon, Dr Anna Casals Antich, Dr Gulelala (Gul) Azhar Dental Surgeons.
Dr Casey Prawiradiraja, Dr George De Castro Torres and Dr Jonathan (Jonnie) Dixon, Dental Surgeon, Dental Surgeons. Dr Konstantinos (Kostas) Tzamalas, Specialist Orthodontist.
Mrs Nur Gilmartin Dental Hygienist. Dr Etienne Deysel, Sedationist. Miss Sam Singleton, Practice Manager.

Confidential Medical History Form

Title: **Forename:** **Surname:** **Date of birth:** // // **Sex:**

Address:

Tel no: (Home): **(Work):** **(Mobile):**

Email Address (Personal): **Email address (Work):**

How long since received dental treatment: **Occupation:**

Your Doctors Name & Address:

Name of any Dental Insurance you have:

Medical Questions	Yes/No	If yes the please give details below.
Are you a smoker? (Smoking can seriously affect the success of dental treatment and dental health). If Yes how many a day?		
Are you attending or receiving treatment from a doctor, hospital, clinic, or specialist?		
Are you taking any medicines? (Tablets, creams, ointments, injections, inhalers or others)?		
Are you pregnant if yes give projected birth date?		
Are you taking or have you taken steroids (in any form) in the last five years?		
Have you or ever had cancer or are you taking or have you ever taken Bisphosphonates or any other drug related to cancer treatment?		
Are you allergic to any medicines, food, materials or suffer from any hay fever, eczema or any other allergy?		
Have you had rheumatic fever or chorea (St Vitus dance) or history of Infective Endocarditis?		
Have you had any history of any kind of Hepatitis, had jaundice, Liver disease, Kidney disease, Thyroid disease, had a joint replacement or carry a warning card (Heart, kidney, joint)?		
Have you had any blood tests, inoculations, etc in the last 2 years?		
Have you or any of your family been treated with growth hormone or any of your family resided with any one with NV CJD or TB?		
Have you ever had your blood refused by the blood transfusion service and if yes what was the reason?		
Have you been hospitalized? Or been treated as a day case? If “yes” what for & when?		
Have you ever been treated for depression, anxiety, sleeping disorder, panic attacks or ever had a nervous breakdown?		
Have you ever been registered disabled or had disability allowance?		
Do you suffer from ulcers, rashes, itchy skin anywhere on your body or ever get cold sores??		
Have you ever had a bad reaction to a general Anaesthetic or sedation or had a bad reaction to an injection or any other adverse reaction while having dental treatment?		
Do you have arthritis or any other problems with your joints or have you ever been treated for Osteoporosis? If yes give details of any treatment/medication in the last 5 years.		
Have you ever been told you have a heart murmur, other heart problem, angina, high or low blood pressure, have had a heart attack, have a pacemaker, or have you had any form of heart or blood vessel surgery?		
Do you suffer from bronchitis, difficult breathing, snoring or other chest condition or suffer from any breathing or sleeping disorder (COPD or Sleep Apnea)		
Do you suffer from asthma? If yes give details of any asthma medication you have taken in the last 5 years; and if yes give details of the last attack and how many attacks in the last 12 months; and if yes give details of any subsequent hospital admission or visit to casualty		
Do you experience fainting attacks, giddiness, blackouts or epilepsy?		
Are you Diabetic? If yes what type of Diabetes and list your medication?		
Have you ever had a bleeding disorder, taken Warfarin or any other anticlotting agent, or do you bruise easily or bled excessively following a tooth extraction, surgery or injury?		
Do you consume alcohol, and if yes then indicate units per week?		
Have ever been a registered drug addict or treated for substance abuse? Or do you use or have used in previous 6 months, any illegal substances (Pot, Heroin, methadone etc)		

Are there any other aspects concerning your health that you think the dentist should know about? Medical histories help to identify problems that affect your dental health and the effectiveness of your dental care. If you answered yes to any questions e.g. any illness, medication or medical problem please give details below.

Completed by: patient/guardian Signature: Date:

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DENTAL HEALTH HISTORY

Please describe Your Current Dental Problem (Describe the signs and symptoms; how long it has been going on; what attempts have been made to sort out the problem by yourself, your doctor or dentist)

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____

We want to meet Your Expectations. So please indicate what would be a favourable outcome to your presenting problem. (An example might be "Extracting my tooth", "Recementing my crown", "Filling the hole in my tooth", "Stopping the pain".) The more information you give us the easier it will be to meet your expectations.

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If this is your first visit then please give name/location of previous dentist ______________________________
If this is your first visit then please date of your last dental appointment (approx is OK) ______________________________
How often do you brush? ______________________________
How often do you floss? ______________________________
Does your jaw make noise so that it bothers you or others? ______________________________
Do you clench or grind your jaws frequently? ______________________________
Do your jaws ever feel tired? ______________________________
Does your jaw get stuck so that you can't open freely? ______________________________
Does it hurt when you chew or open wide to take a bite? ______________________________
Do you have earaches or pain in front of the ears? ______________________________
Do you have any jaw symptoms or headaches upon awaking in the morning? ______________________________
Does jaw pain or discomfort affect your sleep, daily routine, or other activities? ______________________________
Does jaw pain or discomfort affect your appetite? ______________________________
Do you find jaw pain or discomfort extremely frustrating or depressing? ______________________________
Do you have a temporomandibular (jaw) disorder (TMD)? ______________________________
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? ______________________________
Are you unable to open your mouth as far as you want? ______________________________
Are you aware of an uncomfortable bite? ______________________________
Have you had a blow to the jaw (trauma)? ______________________________
Are you a habitual gum chewer or pipe smoker? ______________________________
When did you last have a Dental Hygienist visit? ______________________________
Are you aware of the relationship between Gum disease and Diabetes? ______________________________
Are you aware of the relationship between Gum disease and Hear Disease? ______________________________

	Yes or No		**Yes or No**
Do you gag easily?	________	Do you wear dentures?	________
Does food catch between your teeth?	________	Do you have difficulty in chewing your food?	________
Do you chew on only one side of your mouth?	________	Are you apprehensive about dental treatment?	________
Do your gums bleed easily?	________	Do your gums bleed when you floss?	________
Do your gums feel swollen or tender?	________	Are your teeth sensitive?	________
Do you prefer to save your teeth?	________	Do you want complete dental care?	________

	Yes or No
Have you had problems with previous dental treatment?	________
Have you ever had dental treatment from an oral surgeon?	________
Have you ever had dental treatment from a specialist dentist?	________
Have you ever had dental treatment in or requiring a visit to or stay in a hospital?	________
Do you avoid brushing any part of your mouth because of pain?	________
Have you ever noticed slow-healing sores in or about your mouth?	________
Are you dissatisfied with the appearance of your teeth?	________

Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids? ____ Cold foods or liquids? ____ Sour foods or liquids? ____ Sweet foods or liquids? ____

Have you ever thought about having:

Cosmetic treatment?	____	Botox or facial fillers?	____	Orthodontics?	____
Implants?	____	Sedation?	____	A smile Make Over?	____

Please add any comments below you would like to add (things we missed or that are important to you or maybe personal/social information which is **relevant** to your Dental Health.)