



General medical history:

Do you suffer or have you suffered from any of the following illnesses?

- 1. Heart / circulatory problems-dizziness yes no
- If yes, what specifically: high or low blood pressure yes no
- Angina pectoris/ heart attack yes no
- Stroke yes no
- Prone to excessive bleeding yes no
- Do you have a pacemaker? yes no

Do you have a problem with your health in any of the following areas?

- 2. Respiratory systemyes no
- 3. Digestive systemyes no
- 4. Metabolic disorders (e.g diabetes).....yes no
- 5. Rheumatic ailments (e.g. rheumatoid arthritis).....yes no
- 6. Hormone disfunction (e.g thyroid gland).....yes no
- 7. Neurological/mental illnessesyes no
- 8. Infections e.g hepatitis, TB, AIDSyes no
- 9. An allergic reaction, e.g to specific medication, metals, latexyes no
- and/or specifically allergic to? _____
- Do you possess an allergy card? yes no
- 10. Eye conditions (e.g. increased intraocular pressure) yes no
- 11. Are you undergoing medical treatment at present?yes no
- If yes, why? _____
- 12. Are you taking any medications at present?yes no
- If yes, what? _____
- 13. Is a care level established?yes no
- 14. Do you smoke cigarettes, cigars, a pipe etc?yes no
- State your average daily consumption _____
- 15. When was your last X-ray? general _____
- for dental purposes _____

Specific dental history:

- 1. Have you ever had an accident with head injuries yes no
- 2. Have you ever had orthodontic treatment? yes no
- 3. Do you frequently suffer from headaches? Morning/afternoon/evening yes no
- 4. Do you suffer from earache or pains around your ear? yes no
- 5. Is it painful when you yawn or open your mouth wide? yes no
- 6. Do your jaw joints make noises? Right or left (please circle the side) yes no
- 7. Do your gums bleed? yes no
- 8. Do you have toothache at the moment? yes no
- 9. Do you have any other problems with your teeth at the moment yes no
- 10. Do you prefer to be treated under local anaesthetic? yes no
- 11. When was your last dentist's appointment? _____
- 12. What treatment did you undergo? _____

For female patients: Please inform your dentist if you are pregnant.

Sign. Dentist