

How many units of alcohol do you drink a week? _____

Are you pregnant? Yes No _____

Have children under 16? Yes No _____

Care for anyone? Yes No _____

Have sleep apnoea? Yes No _____

Have eye surgery? Yes No _____

Have any mental health problems?
 Yes No _____

Please complete the following questionnaire:

- If you went to your dentist for TREATMENT TOMORROW how would you feel?**
 Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious
- If you were sitting in the WAITING ROOM (waiting for treatment) how would you feel?**
 Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious
- If you were about to have a TOOTH DRILLED, how would you feel?**
 Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious
- If you were about to have your teeth SCALED AND POLISHED, how would you feel?**
 Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious
- If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, how would you feel?**
 Not anxious Slightly anxious Fairly anxious Very anxious Extremely anxious

Please circle how you are feeling today:



Please sign and date:

TORRINGTON DENTAL PRACTICE

SEDATION TEAM

CONFIDENTIAL MEDICAL HISTORY

Please complete this form so that we can provide you with safe and comfortable treatment. It is important to include all information requested. If you withhold information you may put yourself at unnecessary risk.

Please use the additional space after each questions to provide any more details.

PERSONAL INFORMATION

Title: _____ Surname: _____

Forename(s): _____ Male Female

Date of Birth: _____

Address: _____

Postcode: _____

Home no: _____

Mobile no: _____

Work no: _____

Email: _____

Are you happy for us to email you? Yes No

Occupation: _____

DENTAL AND MEDICAL HISTORY

Last dentist: _____

When did you last receive dental treatment? _____

Doctors name: _____

Doctors surgery: _____

Phone number: _____

How would you rate your general health?
 Excellent Good Fair Poor

Have there been any recent changes in your health? Yes No

Please provide details: _____

MEDICATIONS – please list any medications you are currently taking, including any prescribed, herbal or recreational medications

SEDATION HISTORY – have you ever had:

Sedation for any procedure? Yes No

If yes, please tick which types:

Tablet Gas and Air Injection in hand/arm Other

What was this for? _____

Have you ever had a general anaesthetic? Yes No

What was this for? _____

Is there any family history of problems with sedation? If yes, please detail:

HEART...have you ever had:

Heart attack? Yes No _____

High blood pressure? Yes No _____

Chest pains/palpitations? Yes No _____

Angina? Yes No _____

Stroke? Yes No _____

Rheumatic fever? Yes No _____

Pacemaker/heart surgery? Yes No _____

Heart murmur? Yes No _____

BLOOD...have you ever had:

Anaemia? Yes No _____

Sickle cell disease? Yes No _____

Excessive bleeding/bruising after treatment or surgery?
 Yes No _____

Blood refused by the transfusion service?
 Yes No _____

Abnormal blood test results? Yes No _____

CHEST...have you ever had?

Shortness of breath walking? Yes No _____

Shortness of breath lying down? Yes No _____

Bronchitis? Yes No _____

TB? Yes No _____

Asthma? Yes No _____

COPD/emphysema? Yes No _____

Cold/chest infection currently? Yes No _____

Cough regularly? Yes No _____

OTHER...have you ever had any of the following?

Fainting/dizziness/blackouts? Yes No _____

Liver disease/jaundice? Yes No _____

Hepatitis? Yes No _____

Kidney disease? Yes No _____

Infectious disease e.g. HIV/CJD? Yes No _____

Gastric ulcer/hiatus hernia? Yes No _____

Diabetes? Yes No _____

Thyroid problems? Yes No _____

Arthritis? Yes No _____

Myasthenia gravis? Yes No _____

ALLERGIES

Do you have any allergies? Yes No _____

Do you have asthma/eczema? Yes No _____

Have you taken any steroid medication in the last two years? If yes, details:

SOCIAL HISTORY...do you...

Smoke? Yes No How many a day? _____

Are you interested in giving up? Yes No _____

Take recreational drugs? Yes No _____