MOONFLEET DENTAL PRACTICE

Wessex Centre for Biological Dentistry

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Date ____________________ Purpose of visit ____________________

GENERAL INFORMATION

Mr., Mrs., Miss, Ms. ____________________ Birthdate ____________________
Last First Middle

Address ____________________

____________________ Telephone ____________________

Occupation ____________________ Mobile ____________________

Referred by ____________________ Email ____________________

METABOLIC PROFILE SURVEY

Height ____________________

Weight ____________________

Waist size ____________________

Hip size ____________________

office use
BMI = W/H =

How would you describe your weight: Stable ○ Increasing ○ Decreasing ○

Have you had a blood test recently? Yes ○ No ○

Are you currently taking dietary supplements? Yes ○ No ○

How stressful would you rate your life? Low 1 2 3 4 5 High

MEDICAL HISTORY

Name of Doctor ______________________ Surgery ______________________

Do you have a current medical problem? Yes ○ No ○ What ______________________

Have you ever had any of the following:

YES	NO		YES	NO	
○	○	Lung trouble (TB, asthma, emphysema)	○	○	Heart attack
○	○	Hepatitis, liver disease, jaundice	○	○	Rheumatic fever
○	○	Arthritis, sore joints	○	○	Heart Murmur
○	○	Diabetes	○	○	High blood pressure
○	○	Excessive Bleeding	○	○	Fainting spells, convulsions, epilepsy
○	○	Blood trouble, anemia, leukemia	○	○	Headaches when lying down
○	○	Kidney Problems	○	○	Glaucoma
○	○	Shortness of breath	○	○	Nervous breakdown, psychotherapy
○	○	Positive HIV test	○	○	Using Other medicines (please specify)

Medicine For

____

____

____

____

Are you now:

YES	NO	
○	○	Pregnant or nursing a child
○	○	Using Thyroids
○	○	Using hormones (including birth control)
○	○	Using anticoagulents
○	○	Excessive Bleeding

Are you now taking or using medicines for:

YES	NO		YES	NO	
○	○	Diabetes	○	○	Blood (liver, iron pills, blood thinners)
○	○	Nerves (tranquilizers)	○	○	Stomach trouble (ulcer, other)
○	○	Sleeping	○	○	Headaches
○	○	Heart or blood pressure	○	○	Arthritis or rheumatism
			○	○	Allergy

Have you ever been sick from, shown an allergy to, or told not to take

YES	NO		YES	NO	
○	○	Antibiotics	○	○	Dental Anaesthetic
○	○	Pain medications	○	○	Other drugs or medicines (please specify)
○	○	Narcotic drugs			______________________
○	○	Aspirin			______________________

Have you ever had a tumor or cancer? Yes ○ No ○ Where? ______________________

Have you ever had a major operation? Yes ○ No ○ What kind? ______________________

Average Alchohol Intake .... units / week

Have you ever been involved in a serious accident? Yes ○ No ○ Describe: ______________________

Comments: ______________________

____

____

DENTAL HISTORY

	YES	NO
Have you come to this dental practice for relief of pain?	○	○
If YES, where is the pain? ____________________		
Have you had the pain more than 3 weeks?	○	○
Are you presently having dental pain?	○	○
Have you had orthodontic treatment?	○	○
Do you have unreplaced missing teeth?	○	○
If YES, why haven't you had them replaced? ____________________		
Was it ever suggested?	○	○
Do you have difficulty swallowing?	○	○
Do your gums bleed when brushing your teeth?	○	○
Have you ever been told you have gum disease?	○	○
Have you ever had professional instructions on dental home care?	○	○
Is any part of your mouth sensitive to temperature, or pressure?	○	○
If YES, which part? ____________________		
Does food catch between your teeth?	○	○
If YES, where? ____________________		
Do you have any pain or soreness around the eyes, or ears?	○	○
Do you have any unpleasant odor, or taste, in your mouth?	○	○
Do you always have something to be treated or repaired when you visit a dentist?	○	○
Do you feel that in the past you have required a lot of dental work?	○	○
If YES, has it been to replace previous dentistry, or to repair a new decay?	Replace ☐	New Decay ☐
Do you feel that you will lose more teeth and eventually have to wear full dentures?	○	○
If so, at what age? ____________________		
Are you deeply concerned about the finances required to return your mouth to dental health?	○	○
Are you a current smoker?	○	○
Do you have a past history of smoking? If answer to 12 or 13 is YES, please give brief details, ie. how much per day, how many years, etc.? ____________________	○	○

AESTHETIC EVALUATION

Please circle the appropriate answer

	YES				NO
Are you satisfied with your teeth and their appearance?	5	4	3	2	1
Are you self-conscious about your teeth when you smile?	5	4	3	2	1
Do you ever cover your smile with your hand?	5	4	3	2	1
Do you wish your teeth were whiter?	5	4	3	2	1
Do you wish your teeth were shaped differently?	5	4	3	2	1
Do you have any discoloured teeth?	5	4	3	2	1
Have aesthetic dental procedures ever been recommended to you?	5	4	3	2	1

OCCLUSAL SCREENING

	YES	NO
1. Do you clench or grind your teeth during the day?	○	○
2. Have you been made aware of clenching or grinding your teeth during the night?	○	○
3. Do you have chronic headaches, or neck and shoulder pains?	○	○
4. Are your jaws or teeth tired when you awaken?	○	○
5. Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and about the ears)?	○	○
6. Have your jaws ever clicked or popped when you open your mouth?	○	○
7. Have you ever experienced difficulty moving your jaw or opening your mouth wide?	○	○
8. Do you chew on only one side of your mouth?	○	○

DENTURES

	YES	NO
Do any of your family, including your parents, wear dentures?	○	○

How many dentures do you wear? ______________________________

How long have you worn dentures? ______________________________

Why were your teeth extracted? ______________________________

If you are currently having a denture problem, is it related to:

Pain ○ Discomfort ○ Appearance ○ Function ○

I have completed this preclinical examination questionnaire to the best of my knowledge

Signature ______________________________ Date ____________
(Parent if patient is a minor)

Reviewed by Dr.______________________ Date ____________