



MOONFLEET DENTAL PRACTICE

Wessex Centre for Biological Dentistry

John Ahearne BDS MSc MFGDP LFHom(Dent) Mary Ahearne BDS DPDS

30 Bournemouth Road, Lower Parkstone, Poole BH14 0ES Tel: 01202 741622

Fax: 01202 749611 www.moonfleet.co.uk info@moonfleet.co.uk

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 | |
|-----------------------|-----------------------|--------------------------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Lung trouble (TB, asthma, emphysema) | <input type="radio"/> | <input type="radio"/> | Heart attack |
| <input type="radio"/> | <input type="radio"/> | Hepatitis, liver disease, jaundice | <input type="radio"/> | <input type="radio"/> | Rheumatic fever |
| <input type="radio"/> | <input type="radio"/> | Arthritis, sore joints | <input type="radio"/> | <input type="radio"/> | Heart Murmur |
| <input type="radio"/> | <input type="radio"/> | Diabetes | <input type="radio"/> | <input type="radio"/> | High blood pressure |
| <input type="radio"/> | <input type="radio"/> | Excessive Bleeding | <input type="radio"/> | <input type="radio"/> | Fainting spells, convulsions, epilepsy |
| <input type="radio"/> | <input type="radio"/> | Blood trouble, anemia, leukemia | <input type="radio"/> | <input type="radio"/> | Headaches when lying down |
| <input type="radio"/> | <input type="radio"/> | Kidney Problems | <input type="radio"/> | <input type="radio"/> | Glaucoma |
| <input type="radio"/> | <input type="radio"/> | Shortness of breath | <input type="radio"/> | <input type="radio"/> | Nervous breakdown, psychotherapy |
| <input type="radio"/> | <input type="radio"/> | Positive HIV test | <input type="radio"/> | <input type="radio"/> | Using Other medicines (please specify)
Medicine For |

Are you now:

- Pregnant or nursing a child
- Using Thyroids
- Using hormones (including birth control)
- Using anticoagulents
- Excessive Bleeding

Are you now taking or using medicines for:

- | | | | | | |
|-----------------------|-----------------------|-------------------------|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Diabetes | <input type="radio"/> | <input type="radio"/> | Blood (liver, iron pills, blood thinners) |
| <input type="radio"/> | <input type="radio"/> | Nerves (tranquilizers) | <input type="radio"/> | <input type="radio"/> | Stomach trouble (ulcer, other) |
| <input type="radio"/> | <input type="radio"/> | Sleeping | <input type="radio"/> | <input type="radio"/> | Headaches |
| <input type="radio"/> | <input type="radio"/> | Heart or blood pressure | <input type="radio"/> | <input type="radio"/> | Arthritis or rheumatism |
| | | | <input type="radio"/> | <input type="radio"/> | Allergy |

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

- | | | | | | |
|-----------------------|-----------------------|------------------|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Antibiotics | <input type="radio"/> | <input type="radio"/> | Dental Anaesthetic |
| <input type="radio"/> | <input type="radio"/> | Pain medications | <input type="radio"/> | <input type="radio"/> | Other drugs or medicines (please specify) |
| <input type="radio"/> | <input type="radio"/> | Narcotic drugs | | | _____ |
| <input type="radio"/> | <input type="radio"/> | Aspirin | | | _____ |

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

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

Average Alcohol 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?	<input type="radio"/>	<input type="radio"/>
If YES, where is the pain? _____		
Have you had the pain more than 3 weeks?	<input type="radio"/>	<input type="radio"/>
Are you presently having dental pain?	<input type="radio"/>	<input type="radio"/>
Have you had orthodontic treatment?	<input type="radio"/>	<input type="radio"/>
Do you have unreplaced missing teeth?	<input type="radio"/>	<input type="radio"/>
If YES, why haven't you had them replaced? _____		
Was it ever suggested?	<input type="radio"/>	<input type="radio"/>
Do you have difficulty swallowing?	<input type="radio"/>	<input type="radio"/>
Do your gums bleed when brushing your teeth?	<input type="radio"/>	<input type="radio"/>
Have you ever been told you have gum disease?	<input type="radio"/>	<input type="radio"/>
Have you ever had professional instructions on dental home care?	<input type="radio"/>	<input type="radio"/>
Is any part of your mouth sensitive to temperature, or pressure?	<input type="radio"/>	<input type="radio"/>
If YES, which part? _____		
Does food catch between your teeth?	<input type="radio"/>	<input type="radio"/>
If YES, where? _____		
Do you have any pain or soreness around the eyes, or ears?	<input type="radio"/>	<input type="radio"/>
Do you have any unpleasant odor, or taste, in your mouth?	<input type="radio"/>	<input type="radio"/>
Do you always have something to be treated or repaired when you visit a dentist?	<input type="radio"/>	<input type="radio"/>
Do you feel that in the past you have required a lot of dental work?	<input type="radio"/>	<input type="radio"/>
If YES, has it been to replace previous dentistry, or to repair a new decay?	Replace <input type="checkbox"/>	New Decay <input type="checkbox"/>
Do you feel that you will lose more teeth and eventually have to wear full dentures?	<input type="radio"/>	<input type="radio"/>
If so, at what age? _____		
Are you deeply concerned about the finances required to return your mouth to dental health?	<input type="radio"/>	<input type="radio"/>
Are you a current smoker?	<input type="radio"/>	<input type="radio"/>
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.? _____	<input type="radio"/>	<input type="radio"/>

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?	<input type="radio"/>	<input type="radio"/>
2. Have you been made aware of clenching or grinding your teeth during the night?	<input type="radio"/>	<input type="radio"/>
3. Do you have chronic headaches, or neck and shoulder pains?	<input type="radio"/>	<input type="radio"/>
4. Are your jaws or teeth tired when you awaken?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
6. Have your jaws ever clicked or popped when you open your mouth?	<input type="radio"/>	<input type="radio"/>
7. Have you ever experienced difficulty moving your jaw or opening your mouth wide?	<input type="radio"/>	<input type="radio"/>
8. Do you chew on only one side of your mouth?	<input type="radio"/>	<input type="radio"/>

DENTURES

	YES	NO
Do any of your family, including your parents, wear dentures?	<input type="radio"/>	<input type="radio"/>
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 <input type="radio"/>	Discomfort <input type="radio"/>	Appearance <input type="radio"/>
		Function <input type="radio"/>

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 _____