PORTMAN
dental care

TITLE FORENAME SURNAME ______________________
DATE OF BIRTH ______________________
ADDRESS ______________________
POSTCODE ______________ **TEL NO.** ______________
WORK TEL. ______________ **MOBILE.** ______________
EMAIL ADDRESS ______________________
DOCTORS NAME AND ADDRESS ______________________

IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, PLEASE GIVE DETAILS. (eg. medication name)

1.Do you suffer from hearing loss? **YES/NO**
2..Do you suffer from sight loss? **YES.NO**
3.Do you have mobility problems? **YES/NO**
4.How many units of alcohol do you drink in the average week? ______________
(a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)
5.Do you smoke any tobacco products? Yes (how many daily) **YES/NO**
6.Do you chew tobacco, pan, gutkha or supari? **YES/NO**
7.Do you use recreational drugs? **YES/NO**
8.Are you or could you be pregnant? Due date______________ **YES/NO**
9.Do you currently have, or recovered from, any form of cancer? **YES/NO**
10.Are you currently receiving or waiting for any treatment from a hospital or clinic? **YES/NO**
11.Are you currently taking any medications or drugs which are prescribed, bought over the counter or recreational? **YES/NO**
12.Have you ever had any medical conditions related to your heart e.g. heart attack, angina, replacement valve, stent, pacemaker, heart murmur, infective endocarditis, congenital defects, transplant. **YES/NO**
13.Have you ever had any medical conditions related to your circulation e.g. Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm **YES/NO**
14.Have you ever had any medical conditions related to your blood e.g. anaemia, prolonged bleeding following injury, surgery, or tooth extraction, immunity problem. **YES/NO**
15. Have you ever had any medical conditions related to your breathing e.g asthma or Chronic airway disease, sleep apnoea, bronchitis, shortness of breath, pneumonia, persistent cough **YES/NO**
16.Have you ever had any medical conditions related to your nervous system e.g. Fits or blackouts (e.g.epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis **YES/NO**
17.Have you ever had any medical conditions related to your stomach and digestion e.g reflux, Indigestion, ulcers, ulcerative colitis, Crohn's Disease. **YES/NO**
18.Have you ever had any medical conditions related to your liver e.g. Hepatitis, Jaundice, cirrhosis, fatty liver disease, transplant **YES/NO**
19.Have you ever had any medical conditions related to your genital or urinary e.g Kidney disease, prostate problems, gynaecological problems **YES/NO**
20.Have you ever had any medical conditions related to your hormones e.g diabetes, Thyroid problems, Addison's disease **YES/NO**
21.Have you ever had any medical conditions related to your bones or joints e.g. Osteoporosis, arthritis, replacement joints, osteogenesis imperfecta, receive bisphosphonate therapy **YES/NO**
22.Have you ever had any medical conditions related to your skin e.g. eczema, psoriasis, other skin conditions **YES/NO**
23.Have you ever had any medical conditions related to your family (genetic) illness e.g sickle cell anaemia, thalassemia, haemophilia, cleft lip/palate **YES/NO**
24.Have you ever had any medical conditions related to Allergies e.g to medicines, penicillin, foods, substances, hayfever, latex **YES/NO**
25.Have you ever had any medical conditions related to Infectious diseases e.g, HIV, TB, Hepatitis, CJD or any chance you may have contracted these, chicken pox, outstanding immunisations. **YES/NO**
26.Have you ever had any medical condition related to Mental Health problems, e.g anxiety, depression, anorexia, bulimia, psychosis **YES/NO**
27.Have you had any medical conditions related to Learning Disability or developmental delay e.g. any complications before or during birth, premature birth. **YES/NO**
28.Do you weigh over 21 stone? (This is required for health & safety purpose) **YES/NO**

Completed by Self/Parent/guardian Signature :______________ Date:______

Signature of dentist/hygienist:__________________