To help maximise your benefit from your first appointment, please complete these questionnaires and bring them with you

# Welcome to

# Clive Marks'

## Dental Health Practice

At this dental practice our aim is to establish a state of health in your mouth which you will easily be able to maintain. A healthy mouth, with definitively restored teeth, is both a very comfortable mouth and, in the long-term, a cost effective form of dental care for you.

We like to feel that the dental care which we will provide for you, within a friendly relaxed atmosphere, is not only of the highest quality, but also that we are sensitive to your own particular needs and requirements.

This personal dental care does mean that we need to know a little more about you, so we hope that you will help us by completing the questions in this form.

All replies are in strictest confidence between yourself and the practice. Please feel welcome to raise any other queries or make any comments at any time.

Thank you for your help.

Full Name (Prof/Dr/Mr/Mrs/Miss/Ms/Other) _____

Address_____

_____ Post code_____

Date of Birth_____ Occupation_____

Home Phone No._____ Daytime Phone No._____

E-Mail address_____

Doctor's name, address and telephone number_____

_____

How did you come to choose our practice?

recommendation by a friend or relative (please name) _____

web search / Denplan / Yellow pages / advertisement / location / other (please specify)

_____

To help maximise your benefit from your first appointment, please complete these questionnaires and bring them with you

**Your General Health** (please use the back of this sheet to give additional information)

1. Are you taking any medicines / pills / potions? (please list) _____

_____

2. Are you presently under any medical care YES/NO

_____

3. Have you ever had any of the following

   Rheumatic Fever YES/NO

   Congenital heart lesion / Cardiac pacemaker; YES/NO

   Heart attack / Angina; YES/NO

   Blood pressure: High ____ or Low ____ (please tick); YES/NO

   Jaundice, Infective Hepatitis, Liver disease; YES/NO

   Diabetes-Low blood sugar; YES/NO

   Hiatus Hernia / Recurrent stomach trouble; YES/NO

   Epilepsy; YES/NO

   Bronchitis, asthma, or any kind of chest problems; YES/NO

   Digestive problems; YES/NO

4. Have you ever had radiotherapy or chemotherapy? YES/NO
5. Have you ever had any ill effects following dental treatment? YES/NO
6. Have you had any ill effects from local anaesthetic? YES/NO
7. Have you had serious bleeding problems following an extraction? YES/NO
8. Have you ever had a positive result to a blood test for H.I.V.? YES/NO
9. Do you suffer with hayfever or asthma? YES/NO
10. Do you have sinus problems? YES/NO
11. Are you allergic to penicillin or any other antibiotics? YES/NO
12. Are you allergic to, or made ill by, any medication? YES/NO
13. Do you regularly take aspirin or any similar medication? YES/NO
14. Have you had any ill effects from aspirin? YES/NO
15. Have you been in hospital for observation or had any serious illness or major operation (please specify)? _____ YES/NO
16. Have you ever had dizziness, blackouts, giddiness or fainting? YES/NO
17. Are you pregnant or have had a baby within the last year? YES/NO

To help maximise your benefit from your first appointment, please complete these questionnaires and bring them with you

**ABOUT YOUR DENTAL HEALTH** (please use the back of this sheet to give any additional information)

**Pain** (If you need to answer "Yes" to any of these questions, please state where the pain is)

Have you recently had any pain from any of your teeth or in your jaws? YES/NO

Are any teeth sensitive to hot or cold things? YES/NO

Are any teeth sensitive to sweet things? YES/NO

Are any teeth tender when you bite or chew? YES/NO

Are any teeth sensitive to touch? YES/NO

Are you aware of any sharp edges or chipped teeth in your mouth? YES/NO

Do you try to avoid using certain teeth? YES/NO

**Gums**

**"More adult teeth are lost through gum disease than through tooth decay"**

Do you get a bad taste in your mouth or a bad smell to your breath? YES/NO

Do your gums bleed when you brush your teeth? YES/NO

Are your gums ever tender or sensitive? YES/NO

Are you aware of any areas where your gum is receding or shrinking? YES/NO

Does food get trapped between your teeth or gums? YES/NO

**Appearance**

Are you happy with the appearance of your teeth? YES/NO

Is there anything about the colour, shape or position of your teeth that you would like to improve or discuss? YES/NO

**Dentures**

If you wear dentures, how happy with them are you at the present time? YES/NO

VERY / FAIRLY / NOT AT ALL / _____

**Other**

Do you find it difficult to eat, bite or chew your food properly? YES/NO

Do you suffer from headache, migraine or pains in your face, cheek or in your ear? YES/NO

Does your jaw ever "click" or get stuck (further questions overleaf)? YES/NO

Do you suffer from any ulcers or any areas that are sore or swollen in your mouth? YES/NO

Do any of your teeth feel loose? YES/NO

Are there any other problems you would like to discuss with us? YES/NO

To help maximise your benefit from your first appointment, please complete these questionnaires and bring them with you

## OCCLUSION

For most of us, the way in which our teeth meet is not in total harmony with the jaw joints. Normally we are able to cope with these discrepancies most of the time and we therefore function perfectly well.

However, if further physical or emotional stress is added to the system this can tip the balance out of harmony causing a variety of symptoms to develop around the head and neck. Some of these symptoms can seem to be totally unrelated to teeth and can even have been grumbling away for quite some time.

Please be as frank as possible with your answers to the following questions.

### Jaw Joint

Do your jaw joints ever click/pop when you open and close? YES/NO

If "YES", do both of them click or just one? Right / Both / Left

Do you ever have difficulty opening wide or moving the jaw to one side? YES/NO

### Teeth / Jaw

Do you clench or grind your teeth during the day? YES/NO

Do your teeth / jaw feel tired when you wake up? YES/NO

Are you made aware that you clench or grind your teeth during the night? YES/NO

### General, of the head and neck

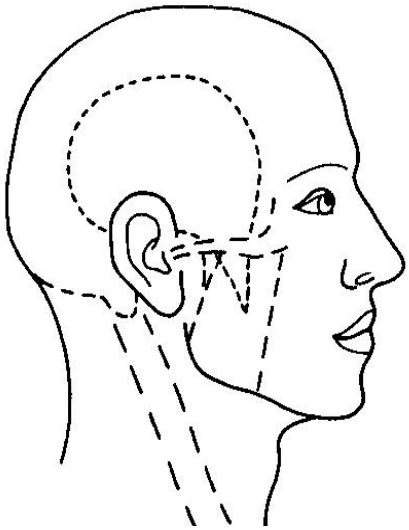
Do you suffer from chronic headaches? YES/NO

Which side of the mouth do you tend to chew with most? Right / Both / Left

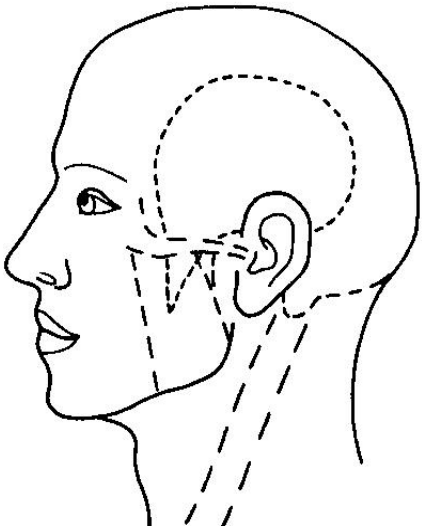
Do you ever have pain in your jaw joints or around your head and neck? YES / NO

If "YES", please indicate on these diagrams where that occurs.

Right side



Left Side



To help maximise your benefit from your first appointment, please complete these questionnaires and bring them with you

## GETTING TO KNOW MORE ABOUT YOU

We believe in treating you as an individual person rather than as "just another patient". Your frank answers to these questions will help us to get to know you and may well influence the actual treatment we need to provide for you.

How much do you worry about a dental visit? A LOT / A BIT / NOT REALLY / NOT AT ALL

What do you worry about most in a dental visit? (please give details) _____

_____

What is the most convenient time/day for you? _____

How highly would you rate the importance of a good appearance for your mouth?
VERY / FAIRLY / NOT AT ALL

How important is it for you to keep your own teeth? VERY / FAIRLY / NOT AT ALL

Do you take active steps to keep fit and healthy? YES/NO

Do you play contact sports or hazardous leisure activities? YES/NO

Do you smoke? YES/NO

How much alcohol do you normally consume per week? _____ units

Do you take sugar in drinks? YES/NO

Do you suck peppermints or eat other sweets on 2 or more days/week? YES/NO

Do you consider that you take diet and nutrition seriously? YES/NO

How much "hidden sugar" do you think is in your diet?
NOT SURE WHAT "HIDDEN SUGAR" IS / A LOT / A BIT / NOT MUCH / NONE

Do you play any woodwind instruments? YES/NO

Is there anything else you feel we should know about you and your life style?

_____

**"AND FINALLY, …"** if a magic wand could be waved over your mouth, what would you want it to achieve? -

_____

_____

_____

If there is anything which you do not understand or need any help with please do not hesitate to ask. We are all here to help you.

Signed _____ Date _____

Thank you for completing all these helpful questions. **Please now return them to our receptionist.**