



# PERSONAL DENTAL ASSESSMENT

PORTOBELLO  
DENTAL CLINIC

Please could you take a few minutes to complete this Personal Dental Assessment.

Please tell us:

Mr / Mrs / Miss / Ms / Dr

You full name .....

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Date of birth .....

Address .....

.....

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Home phone .....

Work phone .....

Mobile .....

Email .....

Occupation .....

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Work address .....

.....

.....

RSI / PPS No. ....

Which of the following statements best describes your feelings about visiting the dentist? Tick the one you agree with

- I feel relaxed
- I feel a little anxious
- I feel very nervous

If you could alter your smile what would you most like to change?

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When did you last visit your dentist?

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We hope you will be very satisfied with the care you receive in our practice. We would like to know what made you choose us. Please choose ONE of the following options.

- I was recommended by a friend / family member - please specify.
- I saw the sign outside.
- I was given your number by 11850 directory enquiries.
- I saw your number in the Golden pages.
- I prefer late evening appointments.
- I prefer the option of sedation for treatment.
- Other reasons, please specify:

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# CONFIDENTIAL MEDICAL HISTORY

Some medical conditions and medicines used to treat them can affect dental treatment. Please read the following and answer the questions about your health. Thank You.

	Yes	No	Further Details
<b>ARE YOU</b>			
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Taking ANY pills, tablets or medicines from your doctor?			
3. Taking or have taken Steroids in the last 2 years?			
4. Pregnant or nursing mother?			
5. Allergic to ANY medicines. e.g. Penicillin, Aspirin, Local Anaesthetic?			
<b>HAVE YOU</b>			
1. A prosthetic heart valve, a history of infective endocarditis, heart transplant or surgery including shunts/conduits or congenital heart disease?			
2. Hypertension, angina or pacemaker?			
3. Had jaundice, liver, kidney disease or any type of hepatitis?			
4. Ever reacted adversely to a General or Local Anaesthetic?			
5. Had any serious illness or operation in the last 3 years?			
6. Ever been refused by the blood transfusion service?			
<b>DO YOU</b>			
1. Suffer from chronic bronchitis, asthma or breathing difficulties?			
2. Suffer from giddiness, black outs or epilepsy?			
3. Suffer from diabetes?			
4. Easily bleed?			
5. Carry a warning card?			
6. Have any other aspects concerning your health?			

Signature: ..... Date: .....