



Dental Assessment

If you are a new patient at O'Hagan & Murray Dental Practice we offer you a warm welcome. We are delighted that you have selected our practice to provide your dental care. So that we can do the best for you, we would like to ask you a few questions which will take around five minutes to answer.

Please could you take a few minutes to complete this Personal Dental Assessment and bring it with you on your next visit.

Your Full Name:

Address:

.....

.....

Postcode:

Daytime Number:

Evening Number:

Email:

Date of Birth:/...../.....

Your occupation?

What is your doctor's name and telephone number?

Do you have any Children? Yes / No Age(s) if Yes

We hope you will be happy and very satisfied with the care you receive in our practice. We would like to know what made you choose us. Where any of the following reasons involved?

How Did You Find Us? (Please Tick)

Convenient location

Recommended by a friend

Convenient surgery hours

Family member already a patient here

Referred by another dentist

The yellow pages

Found on Google

Found on Other Search Engine

When did you visit your last dentist?

Have you left another Dental practice in order to come here? Yes / No



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Medical History

Are you....

- Attending or receiving any treatment from your doctor, hospital, clinic or specialist? Yes / No
- Taking any medicines or tablets prescribed by your doctor? Yes / No
- Allergic to penicillin or any other drug or substance or foods(e.g. latex / rubber) Yes / No
- Pregnant or likely to be so? Yes / No

In the Past have you...

- Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? Yes / No
- Ever had rheumatic fever? Yes / No
- Ever had jaundice, hepatitis, liver problems or kidney disease? Yes / No
- Ever had asthma, bronchitis, hay fever or any serious chest infections? Yes / No
- Ever had blood related diseases? Yes / No
- Ever had a bad reaction to a local or general anesthetic? Yes / No
- Ever had an operation or received hospital treatment? Yes / No
- Ever had a heart valve replaced? Yes / No
- Had a blood transfusion from the blood transfusion service? Yes / No
- Had growth Hormone treatment before the mid 1980's? Yes / No

Do You....

- Have a pacemaker? Yes / No
- Have fainting attacks, giddiness or epilepsy? Yes / No
- Have Diabetes? Yes / No
- Carry a warning card? Yes / No
- Bruise easily or have you ever bled excessively? Yes / No
- Take or have you taken steroids? Yes / No
- Do you smoke? Typically how many per day? Yes / No
- Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jacob disease? Yes / No
- Drink alcohol (A unit is half a lager, a single measure spirit of glass of wine? How many units per week? Yes / No
- Suffer from headaches or migraine? Yes / No
- Suffer from arthritis? Yes / No
- Have an infectious disease such as HIV, CJD or hepatitis, if so what? Yes / No