How many units of alcohol do you drink a week? _____

Are you pregnant? ☐ Yes ☐ No _____

Have children under 16? ☐ Yes ☐ No _____

Care for anyone? ☐ Yes ☐ No _____

Have sleep apnoea? ☐ Yes ☐ No _____

Have eye surgery? ☐ Yes ☐ No _____

Have any mental health problems?

☐ Yes ☐ No _____

Please complete the following questionnaire:

1. **If you went to your dentist for TREATMENT TOMORROW how would you feel?**

Not anxious ☐ Slightly anxious ☐ Fairly anxious ☐ Very anxious ☐ Extremely anxious ☐

2. **If you were sitting in the WAITING ROOM (waiting for treatment) how would you feel?**

Not anxious ☐ Slightly anxious ☐ Fairly anxious ☐ Very anxious ☐ Extremely anxious ☐

3. **If you were about to have a TOOTH DRILLED, how would you feel?**

Not anxious ☐ Slightly anxious ☐ Fairly anxious ☐ Very anxious ☐ Extremely anxious ☐

4. **If you were about to have your teeth SCALED AND POLISHED, how would you feel?**

Not anxious ☐ Slightly anxious ☐ Fairly anxious ☐ Very anxious ☐ Extremely anxious ☐

5. **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, how would you feel?**

Not anxious ☐ Slightly anxious ☐ Fairly anxious ☐ Very anxious ☐ Extremely anxious ☐

Please circle how you are feeling today:

Please sign and date: .....

TORRINGTON DENTAL PRACTICE

SEDATION TEAM
CONFIDENTIAL MEDICAL HISTORY

Please complete this form so that we can provide you with safe and comfortable treatment. It is important to include all information requested. If you withhold information you may put yourself at unnecessary risk.

Please use the additional space after each questions to provide any more details.

PERSONAL INFORMATION

Title: _____ **Surname:** _____

Forename(s): _____ ☐ **Male** ☐ **Female**

Date of Birth: _____

Address: _____

_____

_____ **Postcode:** _____

Home no: _____

Mobile no: _____

Work no: _____

Email: _____

Are you happy for us to email you? ☐ **Yes** ☐ **No**

Occupation: _____

DENTAL AND MEDICAL HISTORY

Last dentist: _____

When did you last receive dental treatment? _____

Doctors name: _____

Doctors surgery: _____

Phone number: _____

How would you rate your general health?

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Have there been any recent changes in your health? ☐ **Yes** ☐ **No**

Please provide details: _____

_____

MEDICATIONS – please list any medications you are currently taking, including any prescribed, herbal or recreational medications

_____

_____

_____

_____

SEDATION HISTORY – have you ever had:

Sedation for any procedure? ☐ Yes ☐ No

If yes, please tick which types:

☐ Tablet ☐ Gas and Air ☐ Injection in hand/arm ☐ Other

What was this for? _____

Have you ever had a general anaesthetic? ☐ Yes ☐ No

What was this for? _____

Is there any family history of problems with sedation? If yes, please detail:

_____

HEART…have you ever had:

Heart attack?	☐ Yes	☐ No	_____
High blood pressure?	☐ Yes	☐ No	_____
Chest pains/palpitations?	☐ Yes	☐ No	_____
Angina?	☐ Yes	☐ No	_____
Stroke?	☐ Yes	☐ No	_____
Rheumatic fever?	☐ Yes	☐ No	_____
Pacemaker/heart surgery?	☐ Yes	☐ No	_____
Heart murmur?	☐ Yes	☐ No	_____

BLOOD…have you ever had:

Anaemia?	☐ Yes	☐ No	_____
Sickle cell disease?	☐ Yes	☐ No	_____
Excessive bleeding/bruising after treatment or surgery?	☐ Yes	☐ No	_____
Blood refused by the transfusion service?	☐ Yes	☐ No	_____
Abnormal blood test results?	☐ Yes	☐ No	_____

CHEST…have you ever had?

Shortness of breath walking?	☐ Yes	☐ No	_____
Shortness of breath lying down?	☐ Yes	☐ No	_____
Bronchitis?	☐ Yes	☐ No	_____
TB?	☐ Yes	☐ No	_____
Asthma?	☐ Yes	☐ No	_____
COPD/emphysema?	☐ Yes	☐ No	_____
Cold/chest infection currently?	☐ Yes	☐ No	_____
Cough regularly?	☐ Yes	☐ No	_____

OTHER…have you ever had any of the following?

Fainting/dizziness/blackouts?	☐ Yes	☐ No	_____
Liver disease/jaundice?	☐ Yes	☐ No	_____
Hepatitis?	☐ Yes	☐ No	_____
Kidney disease?	☐ Yes	☐ No	_____
Infectious disease e.g. HIV/CJD?	☐ Yes	☐ No	_____
Gastric ulcer/hiatus hernia?	☐ Yes	☐ No	_____
Diabetes?	☐ Yes	☐ No	_____
Thyroid problems?	☐ Yes	☐ No	_____
Arthritis?	☐ Yes	☐ No	_____
Myasthenia gravis?	☐ Yes	☐ No	_____

ALLERGIES

Do you have any allergies?	☐ Yes	☐ No	_____
Do you have asthma/eczema?	☐ Yes	☐ No	_____

Have you taken any steroid medication in the last two years? If yes, details:

_____

_____

SOCIAL HISTORY…do you…

Smoke?	☐ Yes	☐ No	How many a day? _____
Are you interested in giving up?	☐ Yes	☐ No	_____
Take recreational drugs?	☐ Yes	☐ No	_____