Title ______ Surname ________________________First Name ______________________ Date Of Birth ___________

Address ____ Post Code ____________

Phone: [H] ( )______________________ [W] ( )______________________ [Mob]_____________________________

E-Mail Address ____ Occupation ________________________

Who referred you to this practice ____

Are you, or have you taken in the past any Bisphosphonates medications? [YES] [NO]

Do you have or have you ever had:	**NO**	**YES**	
High Blood Pressure (Hypertension)?	[ ]	[ ]	**If Yes - Medication?______________________________**
Heart Attack/Pacemaker/ Heart Surgery?	[ ]	[ ]	**If Yes – When___________________________________**
Rheumatic Fever?	[ ]	[ ]	**If Yes – When__________________________________**
Asthma/ Bronchitis/ Emphysema?	[ ]	[ ]	**If Yes – Medication?_____________________________**
Diabetes?	[ ]	[ ]	**If Yes- Do you use Insulin NO YES**
			OR do you take diabetic tablets NO YES
Epilepsy/Seizures/Blackouts/Faints?	[ ]	[ ]	**If Yes – How often______________________________**
Stroke or Cardiovascular accident?	[ ]	[ ]	**If Yes – When__________________________________**
Blood clots or bleeding disorder?	[ ]	[ ]	**If Yes – What type______________________________**
Kidney Condition?	[ ]	[ ]	**If Yes – What type______________________________**
Bone Disease/Osteoporosis?	[ ]	[ ]	**If Yes - What type ______________________________**
Hepatitis or liver Condition?	[ ]	[ ]	**If Yes – What type______________________________**
Joint replacement surgery?	[ ]	[ ]	**If Yes- What type & when________________________**
Any other operations?	[ ]	[ ]	**If Yes- What type & when________________________**
Allergic Reactions?	[ ]	[ ]	**If Yes – What __________________________________**
Cancer?	[ ]	[ ]	**If Yes- When___________________________________**
Radiotherapy/ Chemotherapy?	[ ]	[ ]	**If Yes – When__________________________________**
Do you smoke?	[ ]	[ ]	**If Yes – How much______________________________**
Do you drink alcohol?	[ ]	[ ]	**If Yes – How much per week_______________________**
Are You Pregnant? (women only)	[ ]	[ ]	**If Yes- How many months_________________________**

Are you currently taking any Medication? Please list ____

____

____

Please mark all relevant conditions past or present:

☐ LEUKEMIA	☐ PARKINSON'S DISEASE	☐ ITCHING
☐ M.S.	☐ LOW BLOOD PRESSURE	☐ ACNE
☐ HERPES	☐ ANGINA	☐ ROOT THERAPIED TEETH
☐ WHIPLASH INJURY	☐ TACHYCARDIA	☐ NERVOUS DISORDERS
☐ IVF PROGRAM	☐ PALPITATIONS	☐ MUSCLE TWITCHES
☐ CHRON'S DISEASE	☐ ANAEMIA	☐ BELL'S PALSY
☐ MENIERE'S DISEASE	☐ FAINTING TENDENCY	☐ MOVEMENT PROBLEMS
☐ INFECTIOUS DISEASES	☐ DERMATITIS	☐ SPEECH PROBLEMS
☐ SHINGLES	☐ ECZEMA	☐ LEG JERKS

- [ ] RESTLESS LEGS
- [ ] NUMB OR TINGLING SENSATIONS
- [ ] CHOKED FEELING
- [ ] FLASHING LIGHTS
- [ ] AIR HUNGER
- [ ] MUSCLE WEAKNESS
- [ ] MUSCLE ATROPHY
- [ ] SHOOTING PAINS
- [ ] OSTEO ARTHRITIS
- [ ] SOUR TASTE
- [ ] METALLIC TASTE
- [ ] DRY MOUTH
- [ ] EXCESSIVE SALIVA
- [ ] FREQUENT URINATION
- [ ] KIDNEY PROBLEMS
- [ ] SHORTNESS OF BREATH
- [ ] CHEST PAINS
- [ ] HEART OR LUNG CONDITIONS
- [ ] FORGETFUL
- [ ] DEPRESSION
- [ ] POOR CONCENTRATION
- [ ] HALLUCINATIONS
- [ ] SUICIDAL FEELINGS
- [ ] SUDDEN ANGER
- [ ] RAPID MOOD SWINGS
- [ ] IRRITABILITY
- [ ] LIGHT SENSITIVITY
- [ ] GUT PROBLEMS
- [ ] COLITIS
- [ ] DIARRHOEA
- [ ] CONSTIPATION
- [ ] ULCERS
- [ ] IRRITABLE BOWEL
- [ ] HEART BURN
- [ ] THYROID PROBLEMS
- [ ] COLD HANDS & FEET
- [ ] FREQUENT COLDS
- [ ] PROSTATE PROBLEMS
- [ ] ENDOMETRIOSIS
- [ ] PITUITARY PROBLEMS
- [ ] CHRONIC FATIGUE
- [ ] CHRONIC SORE THROATS
- [ ] BACK PAIN
- [ ] FOOT PROBLEMS
- [ ] SCOLIOSIS
- [ ] HEADACHE how often__________
- [ ] MIGRAINE how often___________
- [ ] NECK & SHOULDER PAIN
- [ ] PAIN IN ARMS & HANDS
- [ ] RSI
- [ ] SCALP TENDERNESS
- [ ] JAW PAIN
- [ ] FACE PAIN
- [ ] TEETH PAIN
- [ ] LIMITED MOUTH OPENING
- [ ] PAIN WHEN CHEWING
- [ ] DOES YOUR JAW LOCK
- [ ] DOES YOUR JAW CLICK
- [ ] BLURRED VISION
- [ ] DRY ITCHY EYES
- [ ] SINUSITIS
- [ ] EAR PAIN
- [ ] DIZZINESS
- [ ] RINGING IN EARS
- [ ] REDUCED HEARING
- [ ] TOOTH GRINDING
- [ ] CANDIDIASIS
- [ ] HYPOGLYCAEMIA
- [ ] PERIPHERAL NEURITIS

Have you had treatment with;

- [ ] HUMAN GROWTH HORMONE
- [ ] HUMAN PITUITARY HORMONE
- [ ] INFERTILITY TREATMENT
- [ ] HAVE YOU HAD A BLOOD TRANSFUSION, if yes when? ________________________
- [ ] HAVE YOU HAD NEURAL SURGERY
- [ ] HAVE YOU HAD A CORNEAL IMPLANT

Are you under the care of any other Health care practitioner? eg. Medical, homeopathy, naturopath etc. We are happy to communicate with them if you wish ____

Are there any medical conditions about which you would like to speak privately to the dentist? [YES] [NO]

Is there any other information which may be relevant to your condition?

____

____

____

____

Signature ____ **Date** ___________________________