1

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 taken, 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** _____