NAME: ..... PT NUMBER: ……..

	YES	NO	GIVE DETAILS
1. Are you pregnant, possibly pregnant, or breastfeeding?			
2. Are you currently receiving treatment from a doctor, hospital or clinic?			
3. Do you suffer from allergies, including hay fever, eczema, any medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? Or have you got a history of adverse effects to dental materials? **Please give details**			
4. Are you carrying a medical warning card?			
5. Do you suffer from bronchitis, asthma or other chest conditions?			
6. Do you suffer from fainting attacks, panic attacks, giddiness, blackouts or epilepsy?			
7. Do you suffer from heart problems; Have a pacemaker, angina, heart murmur, blood pressure problems or stroke? Have you ever had rheumatic fever? If so, which?			
8. Are you diabetic?			
9. Do you suffer from arthritis?			
10. Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?			
11. Do you suffer from any infectious diseases (including HIV and hepatitis)?			
12. Have you ever had liver disease (e.g. Jaundice, hepatitis) or kidney disease?			
13. Have you ever had Blood Refused by the Blood Transfusion Service? If so why?			
14. Have you ever had a bad reaction to general or local anaesthetic?			
15. Have you ever had heart surgery or brain surgery? Which?			
16. Do you have any close relatives (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jacob Disease (CJD), or received growth hormone treatment before the mid 1980s?			
17. Have you ever had radiation therapy to head or neck?			
18. Do you have a history of mental health problems?			
19. Do you now, or have you ever, suffered from any eating disorders?			
20. Do you suffer from Gastro-Oesophageal or Acid Reflux?			
21. Any other conditions not listed here?			
22. Do you take Bisphosphonate medication for your bones? Have you in the past? Are you likely to in the future (for osteoporosis / steroid use / bone cancer / Padget's disease)			

23 **PLEASE LIST ALL MEDICATIONS BELOW:**

24. Ethnicity: ……..

25. Where is your current GP Practice? ……

Email Address.....
House Name or Door Number..... Post Code.....Mobile Number.....
Preferred Communication Method : Text ☐ E-mail ☐

PATIENT SIGNATURE : _____ DATE: _____

PLEASE TURN OVER TO FILL OTHER SIDE

DENTIST SIGNATURE : _____ DATE: _____

Social History

		Yes	No
1.	Do you use fluoride toothpaste?		
2.	As far as you are aware do you clench or grind your teeth?		
Which of the following do you have daily?			
3.	Medicines containing sugar – Daily		
4.	Sugary carbonated (fizzy) drinks such as Isotonic sports drinks and Acidic fruit juices- Daily		
5.	Diet carbonated (fizzy) drink – Daily		
6.	Sugary treats between meals- Daily		
7.	Sugar in hot drinks – Daily		
8.	Sugary snack or drink before bedtime – Daily		
9.	Have you had tooth decay in the last 2 years?		
10.	Do you smoke cigarettes or use any form of tobacco? **Please circle:** Cigarettes, Pan, E-cigarettes, Gutkha, Supari		
11.	If you answered yes, how many per day? Or how often?		
12.	Do you drink alcohol?		
13.	If you answered yes, approximately how many units per week do you drink? *one unit is approximately:* *third of a pint of beer;* *half a small glass of wine;* *one single spirit;*		
The following questions are for **CHILDREN ONLY**			
14.	Do you have any brothers/sisters who have had tooth decay in the last 2 years?		
15.	Do you wear orthodontic braces? (fixed or removable)		