Loughrea Dental
Better mouth, better health

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Confidential Essential Health Information

Like all dentists, we ask patients for information about their general health to help us fully assess their dental health and to help us treat them safely. Please write your contact details below, answer the health questions and then sign the form with the date of signature.

Thank you.

Surname: _____ First names: _____ Title (Mr., Mrs., etc.): _____

Sex (M/F): _____ Date of Birth: _____ Prefer to be called: _____

Address: _____ PPS Number: _____

Tel Home: _____ Work: _____ Mobile: _____

E:Mail: _____ Occupation: _____

Person to contact in case of an emergency: _____Phone No: _____

Doctor's name: _____ Phone no: _____ Medical Card No: _____

If under 16; Please provide parent/guardian's name here: _____

Are you:	Yes	No
1. Attending or receiving any treatment from a doctor, hospital or clinic?	☐	☐
2. Pregnant?	☐	☐
3. Carrying a warning card?	☐	☐
4. Allergic to any medicines, (e.g. antibiotics), substances (e.g. latex) or food?	☐	☐
Please give details: _____		
5. Taking or using any medicine, pills, tablets, ointments, injections or any other drug, (Including contraceptives and HRT)?	☐	☐
Please give details of medication: _____		

Do you suffer from:

1. Headaches, fainting attacks, blackouts or epilepsy?	☐	☐
2. Hay fever, asthma or a chest condition?	☐	☐
3. Heart problems, angina or stroke?	☐	☐
4. High or low blood pressure?	☐	☐
5. Diabetes? If so, what type?	☐	☐
6. Arthritis?	☐	☐
7. Bruising / Persistent bleeding following injury / tooth extraction?	☐	☐
8. Any infectious diseases (including HIV or Hepatitis)?	☐	☐

Did you, as a child or since, have:	Yes	No
Rheumatic fever or chorea (St Vitus dance)?	☐	☐
Liver disease (e.g. jaundice, hepatitis or kidney disease)?	☐	☐
Blood refused by the blood transfusion service?	☐	☐
A bad reaction to general or local anaesthetic?	☐	☐
A joint replacement or other implants?	☐	☐
Treatment that required you to be in hospital?	☐	☐
Heart surgery?	☐	☐
Brain surgery?	☐	☐
Growth hormone treatment before the mid 1980s?	☐	☐
A parent, sibling, child, grandparent, grandchild with Creutzfeldt Jakop Disease?	☐	☐
Any other serious illness?	☐	☐
Chemotherapy / Radiotherapy?	☐	☐

Do you or did you smoke? If so how many per day? _____

Have you had a specific stressful event recently?
(Such as bereavement, marriage, divorce, new job, lost job etc) _____

Has anyone in your immediate family had gum disease or heart problems/stroke? _____

Has anyone else in your immediate family had lung disease or Alzheimer's? _____

When did you last have *regular* dental treatment? _____

Please tell us what you saw the dentist for _____

Is there any part of dentistry that worries you? _____

Have you had any problem with dental treatment in the past? _____

Can we thank anyone for recommending you to us? _____

CANCELLATION POLICY:

We would ask you to please give us 1 day notice if you are unable to attend your appointment. Patients who repeatedly fail to attend or cancel appointments at short notice will be asked to pay an appointment retention deposit for any further appointments.
Thank you for your co-operation.

Signature: _____ Date: _____

We look forward to getting you dentally healthy at Loughrea Dental