1. DENTURE REPLACEMENT **HISTORY TAKING - PATIENT INSTRUCTIONS**

Background

- You are 48ish years old.
- You are retired from the police.
- You are married and have 2 teenage children.
- **Use a name and date of birth of your choosing if asked.**

Presenting complaint

- Your false teeth (F/F) are about 20 years old and getting a bit loose. This has been getting worse over the last 6 months.
- About a month ago you were roaring with laughter at something that your children said and your lower set of teeth fell out.
- You were quite embarrassed by this, as you don't even take your teeth out when you go to sleep at night.
- You also have a bit of pain, there is a sore spot under the lower denture at the front. The denture rubs this area and you have been taking your teeth out between meals when no one else is at home.
- Your biggest worry is the sore area under your denture. You are pretty sure that it is just because the teeth are loose. However, deep down you worry it might be cancer as you saw a TV programme about this recently.

Medical History

- You take blood pressure medication (atenolol, can't remember the dose)
- Pain killers for back problem.
- You have no allergies.
- You have no other health problems.

Social history

- You were medically retired due to a work related back injury. You have recovered well but still need to take medication for it. See above
- You can easily attend appointments as you are retired.
- You smoke about 10 cigarettes a day. You would like to give up or cut down.
- You drink alcohol, about 2-4 glasses of wine a night.

Dental history

- You are not a regular attender; now that you have false teeth you only go to the dentist when you have problems. You haven't been in about 5 years.
- You are not dentally anxious.
- You brush your dentures about once a week.

After taking your history the dentist will suggest an examination.

DENTAL MEDICAL HISTORY FORM

NHS Grampian

Like all dentists, we may ask patients for information about their general health and any medicines being taken, to help us to treat them safely. Please write your contact details below, answer the health questions and then sign the form on the back page. If you have any questions about the form content, or feel that you cannot answer some of the questions, please seek clarification from the Dentist treating you. We will show you the form at later visits so that you can tell us whether there has been any change in your general health. All information will be kept strictly confidential.

Surname | Title | Date of last dental treatment: 2017

First Name | Are you exempt from dental charges?

Date of Birth | Yes | No ✓

Address: 1 Pond lane, Banchory, Aberdeenshire | Exemption category

Postcode: AB31 5BN | Doctor's name: Dr Stevenson

CHI | Doctor's address: Bellfield Surgery, Banchory

If we need to contact you by telephone and are unable to speak to you directly, do we have your consent to leave a message either on an answering service or with the person who answers the phone on the number you have given us? **YES/ NO**

Home Tel.No.: 01330822222 | Doctor's Tel.No.: 01330825888

Daytime Tel.No. | Occupation: Retired

Mobile Tel.No.: 07891234567

Are you currently...	**Yes**	**No**	**Give Details**
01. Pregnant		✓	
02. Receiving treatment from a doctor, hospital or clinic?		✓	
03. Taking any prescribed medicines (e.g tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?	✓		Blood pressure pill, atenolol. painkillers for back injury
04. Carrying a medical warning card?		✓	
05. Have you taken any steroids in the last 12months?		✓	
Do you suffer from...	**Yes**	**No**	**Give Details**
06. Allergies to medicines, food or substances?		✓	
07. Hay fever or eczema?		✓	
08. Bronchitis, asthma or other chest conditions?		✓	
09. Fainting attacks, giddiness, blackouts or epilepsy?		✓	
10. Heart problems, angina, blood pressure problems, stroke, or heart murmur?		✓	
11. Diabetes (or does anyone in your family?)		✓	
12. Arthritis?		✓	

13. Bruising or persistent bleeding following injury, tooth extraction or surgery?		✓	
14. Any infection or diseases? (Including HIV and Hepatitis)?		✓	
Did you, as a child or since, have:	**Yes**	**No**	**Give Details**
15. Rheumatic fever of chorea?		✓	
16. Liver disease (e.g. jaundice, hepatitis) or kidney disease?		✓	
17. Any other serious illness?		✓	
18. Have you ever had your blood refused by the Blood Transfusion Service?		✓	
19. A bad reaction to general or local anaesthetic?		✓	
20. A joint replacement or other implant?		✓	
21. Treatment that required you to be in hospital?	✓		Back injury
22. Heart surgery?		✓	
23. Brain surgery?		✓	
24. Growth hormone treatment before the mid-1980's?		✓	
25. A close relative (parent, sibling, child, grandparent or grandchild) with Creutzfeldt Jakob Disease (CJD)?		✓	
26. Any history of behavioural problems?		✓	

Drinking	**Units per week**
27. How many units of alcohol do you drink per week?	About 14-28 units
(A unit is a half pint of lager, a single measure of spirits or a single glass of wine/ aperitif)	2-4 glasses of wine a night

Smoking and Chewing	**Yes**	**No**	**In Past**	**Quantity**
28. Do you smoke any tobacco products now (or did you in the past)? How many times per day?	✓			10 cigarettes a day
29. Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)? How many times per day?		✓		

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg Aspirin)

Form completed by (*Please Tick*) **Self** ✓ **Parent** **Guardian**

Signature **Date**

MEDICAL HISTORY UPDATE

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.