2. POSSIBLE GUM DISEASE **HISTORY TAKING - PATIENT INSTRUCTIONS**

Background

- You are 40ish years old.
- You work as a HR manager in an oil company.
- You are married with 2 teenage children
- **Use a name and date of birth of your choosing if asked.**

Presenting complaint

- You are attending for an emergency appointment.
- Your gums have also been bleeding every time you brush and are a bit tender to brush. If asked, the discomfort is about 2 out of 10.
- Your teeth look at bit stained, you are becoming conscious of how they look.
- Your teeth feel as if they have moved. There is a space between your upper front teeth that appears to be getting bigger. The teeth also feel as if they are sticking out a bit more than they used to, you feel like they are beginning to look a bit horsey.
- You are also worried that you have bad breath and are really embarrassed about this.
- You are afraid that you will lose your teeth.

Medical History

- You take no medications.
- You have no allergies.
- You have no other health problems.

Social history

- You can easily attend appointments.
- You smoke about 20 cigarettes a day, probably more at the weekend. You would like to give up or cut down.
- You barely drink alcohol 1-2 glasses of red wine a week, but you do drink a lot of coffee!

Dental history

- You are not a regular attender; you only go to the dentist when you have problems. You haven't been for a few years now.
- You have previously had a couple of fillings and a root treatment.
- As a result of this you have a bit of dental anxiety.
- You brush 2x /day, with fluoride toothpaste.
- You do not use floss or interdental brushes.

After taking your history the dentist will suggest an examination.

.DENTAL MEDICAL HISTORY FORM

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 ______

First Name ______

Date of Birth ______

Address 1 Pond lane, Banchory, Aberdeenshire

Postcode AB31 5BN

CHI ______

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

Daytime Tel.No. ______

Mobile Tel.No. 07891234567

Date of last dental treatment 2019

Are you exempt from dental charges?

Yes ☐ No ✓

Exemption category ______

Doctor's name Dr Stevenson

Doctor's address Bellfield Surgery
Banchory

Doctor's Tel.No. 01330825888

Occupation HR manager

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)?		✓	
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?		✓	

	Yes	No	Give Details
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?		✓	
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?	1-2
(A unit is a half pint of lager, a single measure of spirits or a single glass of wine/ aperitif)	

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?	✓			20 cigarettes / 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.