

General Questions:

- name:
 address:
 postcode and city:
 date of birth:
 Occupation:
 name of medical GP:
 name of specialist:
 date:
1. Have you ever experienced medical problems or complications during surgery or dental treatment? If so, Nature of the complications?..... Which dentist?.....
2. Have you ever had medical problems related to the use of medication? If so, Nature of the problems?..... Which medication?.....

medical risk based on patient's history:	ASA score	Interaction with dental treatment and preventive measures:					
1.....	.....	date:	date:	date:	date:	date:	date:
2.....	.....	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no
3.....	.....	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no
4.....	.....	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no
Updating of patient's history (oral):	date:	date:	date:	date:	date:	date:	date:
1. Have you seen your medical GP or specialist in the last year? yes/no Nature of the complaints:.....	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no
2. Have there been any changes in your state of health recently? yes/no	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no
3. Has there been any change in your medication recently? yes/no	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no	yes/no

YES NO ASA

- 1. Do you experience chest pain upon exertion (angina pectoris)? If so, Are your activities restricted? Do you have chest pain at rest? Have the complaints increased recently?
0 0 II
0 0 III
0 0 IV
0 0 IV
- 2. Have you ever had a heart attack? If so, Are your activities restricted? Have you had a heart attack in the last 6 months?
0 0 II
0 0 III
0 0 IV
- 3. Do you have a heart murmur, or heart valve disease, or an artificial heart valve? Have you had heart or vascular surgery within the last six months? Do you have a pacemaker? Have you ever had rheumatic heart disease? Are your activities restricted?
0 0 II
0 0 II
0 0 III
0 0 III
0 0 III
- 4. Do you have heart palpitations without exertion? If so, Do you have to rest, sit down or lie down during palpitations? Are you short of breath, or pale or dizzy at these times?
0 0 II
0 0 III
0 0 IV
- 5. Do you suffer from heart failure? If so, Are you short of breath lying flat? Do you need two or more than 2 pillows at night due to shortness of breath?
0 0 II
0 0 III
0 0 IV
- 6. Have you now or in the past had high blood pressure? Write down your last known blood pressure.....
0 0 II
- 7. Do you have a tendency to bleed? If so, Do you bleed for more than one hour following injury or surgery? Do you suffer from spontaneous bruising?
0 0 II
0 0 III
0 0 IV

YES NO ASA

- 8. Do you have epilepsy? If so, Is your condition getting worse? Do you continue to have attacks despite medication?
0 0 II
0 0 III
0 0 IV
- 9. Do you suffer from asthma? If so, Do you use any medication and/or inhalers? Is your breathing difficult today?
0 0 II
0 0 III
0 0 IV
- 10. Do you have other lung problems or a persistent cough? If so, Are you short of breath after climbing 20 steps? Are you short of breath getting dressed?
0 0 II
0 0 III
0 0 IV
- 11. Have you ever had an allergic reaction to penicillin, aspirin, latex, dental materials or anything else? If so, Did this require medical or hospital treatment? Was it during a dental visit? What are you allergic to?
- 12. Do you have diabetes? Are you on insulin? If so, Is your diabetes poorly controlled at present?
0 0 II
0 0 III
0 0 III
- 13. Do you suffer from thyroid disease? If so, Is your thyroid gland underactive? Is your thyroid gland overactive?
0 0 II
0 0 III
0 0 IV
- 14. Have you now or in the past had liver disease?
0 0 II
- 15. Do you have kidney disease? If so, Are you undergoing dialysis? Have you had a kidney transplant?
0 0 II
0 0 III
0 0 IV

YES NO ASA

- 16. Have you ever had or do you have cancer or leukemia? What is the disease? Are you receiving drug therapy of have you had a bone marrow transplant for this? Which medication? Have you ever had X-ray treatment for a tumour or growth in the head or neck?
0 0 II
0 0 III
0 0 IV
- 17. Do you suffer from hyperventilation?
0 0 II
- 18. Have you ever fainted during dental or medical treatment?
0 0 II
- 19. Are you on medication for any reason at present, prescribed or otherwise? - for a heart complaint? - anticoagulants? - for high blood pressure? - aspirin or other pain-killers? - for diabetes? - for an allergy? - Prednisone, corticosteroids (systemic or topical)? - drugs against transplant rejection? - drugs against skin, bowel or rheumatic diseases? - for cancer or blood disease? - penicillin, antibiotics or antimicrobials? - for sleeping disorder, depressive condition or anxiety state? - have you ever used recreational drugs? - other medication (prescribed or otherwise?
- 20. Do you have to take antibiotics before dental treatment?
0 0 II
- 21. Women only, please: Are you pregnant?
0 0 II