

Medical Questionnaire

Surname.....Title.....
 Forenames.....
 Date of Birth.....
 Address.....
 Postcode.....
 Tel Home.....Work.....Mob.....
 E-mail.....
 Next Of Kin.....Tel.....
 Doctor's Name.....Tel.....
 Doctor's Address.....
 Occupation.....

Dental History (date of last visit) / any dental concerns

Are you currently:-	Yes	No	Give details
<i>Attending/receiving treatment from a doctor/hospital/clinic?</i>			
<i>Taking any medicines(e.g tablets, ointments injections or inhalers including contraceptives or HRT)?</i>			<i>List your medication:</i>
<i>Are you/or have you taken steroids in the last 3 years?</i>			
<i>Carrying a warning card?</i>			
<i>Pregnant / possibly pregnant or breastfeeding?</i>			
Do you or have you ever had:-			
<i>Heart, blood pressure, angina or stroke problems?</i>			
<i>Rheumatic fever or St. Vitis Dance? Have you ever been told you require antibiotic cover for dental treatment?</i>			
<i>Bronchitis, asthma or other chest conditions?</i>			
<i>Allergies to any medicines (eg. antibiotics) substances (eg. latex) or foods, Hay Fever or Eczema?</i>			
<i>Fainting attacks, giddiness, blackouts or epilepsy?</i>			
<i>Anaemia including bruising easily or persistent bleeding following(tooth extraction)?</i>			
<i>Diabetes or family history?</i>			
<i>Any infections diseases(HIV or Hepatitis)?</i>			
<i>Kidney or liver problems?</i>			
<i>Repeated cold sores?</i>			
<i>Arthritis?</i>			

	Yes	No	Give Details
Have you had:-			
Blood refused by the Blood Transfusion Service?			
A bad reaction to local or general anaesthetic?			
A joint replacement or other implant?			
Treatment requiring general anaesthetics?			
Any other serious illnesses?			

Drinking	Yes	No	Units Per Week
<i>How many units of alcohol do you drink per week? (A Unit is half a pint of beer, a single measure of spirit or glass of wine)</i>			

Smoking and Chewing	Yes	No	In Past	Quantity Per Day
<i>Do you smoke/chew any tobacco products or did you in the past?</i>				

Please give details which your dentist may need to know about, such as self-prescribed medicines e.g. aspirin/herbal remedies, or any special needs/learning difficulties.

Completed by: Patient/Parent/Legal Guardian (Please circle)

Signature.....Date.....

MEDICAL HISTORY UPDATE

Please check that the health information on this form is still correct including information on smoking and drinking. Please amend as necessary.

<u>Date</u>	<u>No Changes</u>	List any changes below	Patient/Parent/Guardian

Medication and Additional Notes