welcome

thank you for selecting us

medical history questionnaire

Surname (Mr/Mrs/Miss/Ms) .....
Forename .....
Address .....
.....Postcode.....
Tel no. (home).....Tel no. (business).....
Date of Birth.....Occupation .....

Certain medical conditions can affect dental treatment and vice versa
Please complete this form by ticking the appropriate boxes and answering the questions

All details will be strictly confidential

Do you have or have you ever suffered from:	**yes**	**no**
Rheumatic fever?	☐	☐
Any heart complaint. heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Any other serious illness?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you allergic to **any** medicine, tablets, substances or latex? (list below)	☐	☐
at present taking any medicine or tablets? (list below in notes)	☐	☐
pregnant.	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
been treated with hydro-cortisone or corticosteroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or **tell the dentist** if you are HIV positive	☐	☐

What is your average weekly consumption of alcohol? .....
If you smoke, what is your average per week? .....

If 'yes' to any questions please supply details in 'Notes' below or use back of form

Name and address of your doctor:

.....
.....
.....
.....

Notes: .....
.....
.....
.....
.....

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Patients signature: ..... **Date** .....

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