Medical Questionnaire

Surname (Mr, Mrs, Miss, Ms, Mast, Dr,)
Forename(s):
Address:
Postcode

Tel. No. (Home) **Tel. No. (work)**
Tel. No. (Mobile)
E Mail Address
Date of Birth

This is a Medical Questionnaire, the information provided is considered to be a Strictly confidential nature. Which will only be discussed between yourself and your Dentist.
It is essential that your Dentist is aware of any related health issues that may concern your treatment. Please answer all the questions precisely and honestly. If you are unsure of the answer to any of these questions, please inform your Dentist immediately before treatment commences.

Do you suffer (or have you ever suffered) from any of the Following?

Yes	No	
☐	☐	**Rheumatic fever or Chorea**
☐	☐	**Chronic Bronchitis, Asthma or other Respiratory Disease**
☐	☐	**Diabetes (please specify whether any family history)**
☐	☐	**Epilepsy, blackouts, giddiness or fainting**
☐	☐	**Hepatitis, Jaundice, Liver or Kidney Disease**
☐	☐	**Excessive bleeding and/or bleeding disorders**
☐	☐	**High Blood pressure or Angina**
☐	☐	**Heart Disease, Heart Attack or any related complaints**
☐	☐	**Has Heart/Pace-Maker surgery ever been performed?**
☐	☐	**Arthritis**
☐	☐	**Has patient ever undergone a joint replacement operation?**
☐	☐	**Has steroid Therapy been administered in past 2 years**
☐	☐	**Herpes, cold Sores**
☐	☐	**HIV positive**
☐	☐	**Has patient ever undergone blood tests, if so why**
☐	☐	**Has a blood donation ever refused, please state**
☐	☐	**Undergone hospitalisation that may affect Dental Treatment**
☐	☐	**Any other serious illness or related medical condition**
☐	☐	**Is patient currently undergoing any medical treatment?**
☐	☐	**Is patient at present undertaking medication of any sort?**
☐	☐	**Allergies to any medicines, tablets or other materials**
☐	☐	**Allergic reaction to either Local or General Anaesthetic**
☐	☐	**Are there any other know Allergies**
☐	☐	**Is the patient the Mother of a child under 12 months old?**
☐	☐	**Is the patient expecting a baby (please specify due date)?**
☐	☐	**Do you smoke? If you have answered yes how many a day……**
☐	☐	**Do you drink alcohol? If yes how much per week…….**

Additional Information:

Name and Address of GP / Doctor:

Tel. No

Patients signature **Date**