



MEDICAL HISTORY QUESTIONNAIRE

NAME (Dr/Rev/Mr/Mrs/Miss/Ms) -----

ADDRESS -----

-----POSTCODE -----

TEL. NO (HOME) -----WORK/MOBILE -----

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 suffered from:

	yes	no
Rheumatic fever?-----	<input type="checkbox"/>	<input type="checkbox"/>
Heart complaint, heart surgery or stroke?-----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?-----	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or fainting attacks?-----	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or asthma?-----	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis?-----	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding?-----	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?-----	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness?-----	<input type="checkbox"/>	<input type="checkbox"/>
Do you carry a medical warning card?-----	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any medicine, tablets, substances or latex? (list below)	<input type="checkbox"/>	<input type="checkbox"/>
at present taking any medicine or tablets? (list below in notes)	<input type="checkbox"/>	<input type="checkbox"/>
pregnant?-----	<input type="checkbox"/>	<input type="checkbox"/>
In the past 2 years have you undergone any operations?-----	<input type="checkbox"/>	<input type="checkbox"/>
been treated with hydro-cortisone or corticosteroids?-----	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a joint replacement operation?-----	<input type="checkbox"/>	<input type="checkbox"/>
Please tick or tell the dentist if you are HIV positive-----	<input type="checkbox"/>	<input type="checkbox"/>
What is your average weekly consumption of alcohol?-----		
If you smoke, what is your average per week?-----		

IF THE ANSWER IS "YES" TO ANY QUESTIONS PLEASE GIVE DETAILS IN "NOTES" OR USE THE 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 dentist

Patients signature ----- Date -----