MEDICAL HISTORY QUESTIONNAIRE

TITLE / NAME:	**DOB: / /**
ADDRESS:	
HOME NUMBER:	**WORK NUMBER:**
MOBILE NUMBER:	**E MAIL:**

Certain medical conditions can affect dental treatment and vice versa, please complete both sides.

All details will be strictly confidential

DO YOU HAVE OR HAVE YOU SUFFERED FROM?

	Y	N
Rheumatic Fever		
Heart Complaint, heart surgery or stroke		
Diabetes		
Epliepsy or fainting attacks		
Chronic bronchitis or asthma		
Hepatitis		
Excessive bleeding		
High Blood pressure		
Any serious illness		

	Y	N
Do you carry a medical warning card?		
Are you allergic to any medicine, tablet, substances or latex? Please list below		
Are you at present taking any medicines or tablets? Please list below		
Are you Pregnant?		
In the past 2 years have you undergone any operations?		
In the past 2 years, have you 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 / chew tobacco – how much? .....

IF THE ANSWER IS "YES" TO ANY QUESTIONS, PLEASE GIVE DETAILS IN "NOTES" BELOW

Name / Address of your Doctor	Notes and Medicine / tablets List

IF YOU ARE NOT SURE OF ANY OF THE QUESTIONS, OR IF YOUR MEDICAL CIRCUMSTANCES CHANGE, PLEASE INFORM THE DENTIST.

Patients signature: .....Date:...../...../.....

Date of review	Changes	Patient signature
Any changes **Yes ☐ No ☐**		**Dentist's signature**

Date of review	Changes	Patient signature
Any changes **Yes ☐ No ☐**		**Dentist's signature**

DENTAL HISTORY

If you have not answered the following, or are new to the practice please complete;

How did you learn of this practice?	

	YES	NO
Are any of your teeth painful to hot / cold / chewing?		
Do your gums ever bleed?		
Do you ever clench your teeth during the day?		
Have you ever been made aware of grinding your teeth at night?		
Does your jaw joint ever click or feel uncomfortable?		
Do you wear a mouthguard for any reason?		
Have you, or your partner ever noticed that you snore?		
Are you happy with the appearance of your teeth?		
Would you like to have whiter teeth?		
Please indicate if you are interested in the following types of dental treatment: **Dental Implants** □ **Whitening** □ **Teeth Straightening (Invisalign / Inman)** □ **Crowns, Bridges or Veneers** □		

Thank you