MEDICAL HISTORY QUESTIONNAIRE **Please complete this form using BLOCK CAPITALS and BLACK INK**

It is important for your dentist to have your medical history and understand your health needs before any examination or treatment is carried out. If you are a new patient to the practice, please complete the following form for your first assessment. All information provided will be kept strictly confidential.

Your personal details

Title (Mr, Mrs, Miss, Ms, other title)

First name(s) (please include all forenames in full) Surname

Address

Postcode

Date of birth D D M M Y Y Y Y

Home telephone number Work telephone number

Mobile telephone number Email address

Occupation Company name

How did you hear about us? How long since you last visited a dentist?

Details of contact in case of emergency/ Next of Kin

Name Telephone

Are you insured for any dental care? ☐ Yes ☐ No (optional)

If yes, under which insurer or plan? Do you consent to us sharing information about your treatment with them? ☐ Yes ☐ No

Medical History Questionnaire – Confidential

Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions.

GP name

Telephone

Address

Postcode

	Y	N	Give details here and overleaf
Are you presently under medical care (e.g. doctor, hospital, clinic or specialist?)	☐	☐	
Are you taking any medications prescribed by your doctor? (E.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? **If so please state what medication it is**	☐	☐	Please list
Are you taking medication for osteoporosis (e.g. Alendronic Acid)?	☐	☐	
Are you carrying a medical warning card?	☐	☐	
Applicable to women only — Are you pregnant or is it possible you may be pregnant?	☐	☐	
Have you ever suffered from allergies to any medicines i.e. penicillin, substances (e.g. latex/rubber) or foods?	☐	☐	
Have you ever suffered from heart problems, angina, blood pressure problems or stroke?	☐	☐	
Have you ever had liver disease (e.g. jaundice, hepatitis) or kidney disease?	☐	☐	
Have you ever suffered from bronchitis, asthma or other chest condition?	☐	☐	
Have you ever had any form of cancer?	☐	☐	
Have you ever suffered from any infectious diseases (including HIV and hepatitis)?	☐	☐	
Have you ever suffered from a condition that led to your blood being refused by the Blood Transfusion Service?	☐	☐	
Have you ever suffered from fainting attacks, giddiness, blackouts or epilepsy?	☐	☐	
Have you ever had a bad reaction to a local or general anaesthetic?	☐	☐	
Have you ever suffered from diabetes?	☐	☐	
Have you ever had a major operation or recently received hospital treatment?	☐	☐	
Do you have hay fever and/ or eczema?	☐	☐	
Do you have Arthritis?	☐	☐	
Do you have a pacemaker?	☐	☐	
Do you bruise easily or have you ever bled excessively?	☐	☐	
Are you taking, or have you taken, any steroids in the last two years?	☐	☐	
Did you as child or since have growth hormone treatment before the mid 1980s?	☐	☐	
Have you ever been diagnosed or suspected as having variant Creutzfeldt-Jakob disease (vCJD)?	☐	☐	
Have you had heart surgery?	☐	☐	
Have you had brain surgery?	☐	☐	
Is there anything we haven't asked you about that you think we should know?	☐	☐	
Do you smoke, and if yes how many a day?	☐	☐	
Do you drink alcohol? If yes, how many units a week?	☐	☐	
Do you weigh 20 stone/125kg or above?	☐	☐	

Date						Completed by (please tick)
Patient Signature						Self ☐ Parent ☐
Staff Initials						Guardian ☐