Orpington Dental Care

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Medical History Questionnaire

Title: (Mr/Mrs/Miss) ..... D.O.B. .....

Forename: .....

Surname: .....

Address: .....

.....

.....

..... Postcode: .....

Tel No: ..... Mobile / Work: .....

Email: .....

Certain medical conditions can effect dental treatment and vice versa.
Please complete this form by answering the questions with a **'YES'** *or a* **'NO'**.

All details will be strictly confidential

Are you currently receiving treatment from a doctor, hospital or clinic?	YES	NO
Are you currently taking any prescribed medicines?	YES	NO
Are you carrying a medical warning card?	YES	NO
Do you suffer from allergies to any medicines (e.g. penicillin), substances (e.g. latex, rubber) or foods?	YES	NO
Do you suffer from hay fever or eczema?	YES	NO
Do you suffer from bronchitis, asthma or other chest conditions?	YES	NO
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?	YES	NO
Do you suffer from heart problems, angina, blood pressure problems, or stroke?	YES	NO
Are you diabetic (or is anyone in your family?)	YES	NO
Do you suffer from arthritis?	YES	NO
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?	YES	NO
Do you suffer from infectious diseases (including HIV and hepatitis?	YES	NO
Have you ever had rheumatic fever or chorea?	YES	NO
Have you every had any other serious illness?	YES	NO
Have you ever had blood refused from Blood Transfusion Service?	YES	NO
Have you ever had a bad reaction to general or local anaesthetic?	YES	NO
Have you ever had a joint replacement or other implant?	YES	NO
Have you ever had treatment that required you to be in hospital?	YES	NO

Have you ever had heart surgery?	YES	NO
Have you ever had brain surgery?	YES	NO
Did you receive growth hormone treatment before the mid-1980s?	YES	NO
Do you have any close relatives with Creautzfeldt Jokob disease?	YES	NO
Do you regularly drink more than 21 units of alcohol per week?	YES	NO
Do you smoke any tobacco products now (or did you in the past)?	YES	NO
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past?	YES	NO
Are you currently pregnant?	YES	NO
Have you ever had liver disease (e.g. jaundice, hepatitus) or kidney disease?	YES	NO

If you answered 'yes' to any questions please supply details in 'notes' below or use back of form.

Notes: .....

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Name & Address of Doctor: .....

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

How did you hear about us: .....

PATIENTS SIGNATURE: .....

DATE: .....

Date	No change	Details if changed	Patient signature

Notes:

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Thank you for taking the time to complete this questionnaire.