CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

In order to provide the best possible care for you, your dentist needs to be aware of any aspects of your general health which may affect your dental treatment. Please complete this form as fully as possible, if you have any queries please discuss them with your dentist. All information provided will be kept completely confidential. Thank you for your assistance.

Surname:

Forenames: **Title:** Mr/Mrs/Miss/Ms (please circle)

Date of Birth: **Sex:** male/female (please circle)

Address:

Post Code:

Tel (Home): **Tel** (Work): **Tel:** (Mobile):

Occupation:

Date of last dental treatment: **Expectant mother:** Yes / No (Please circle)

Doctor's name and address:

ARE YOU:	YES	NO	IF YES, PLEASE GIVE DETAILS
Attending or receiving treatment from a doctor, hospital, clinic, or alternative therapist?			
Taking any medicines from your doctor? (tablets, ointments, injections, inhalers) **PLEASE LIST ANY MEDICATION.**			
Allergic to any medicines, foods or materials and in particular to penicillin or rubber (latex)?			
HIV Positive?			
HAVE YOU, AS A CHILD, OR SINCE:	**YES**	**NO**	**IF YES, PLEASE GIVE DETAILS**
Had rheumatic fever or chorea (St. Vitus' Dance)?			
Had jaundice, liver or kidney disease or hepatitis?			
Been told you have a heart problem, angina, blood pressure problems, or had a heart attack or stroke?			
Had any problems with your blood cells or immune system?			
Ever had your blood refused by the Blood Transfusion Service?			

PLEASE TURN OVER

HAVE YOU, AS A CHILD, OR SINCE:	YES	NO	IF YES, PLEASE GIVE DETAILS
Had a bad reaction to a general or local anaesthetic?			
Had a joint replacement or other implant?			
Been hospitalised? If yes, what for and when?			
Had any close relative diagnosed with Creutzfeldt-Jakob Disease (CJD) or similar?			
DO YOU:	**YES**	**NO**	**IF YES, PLEASE GIVE DETAILS**
Believe you are in good health? If no, give details			
Have a pacemaker, or have you had any form of heart surgery?			
Suffer from hay fever, eczema or ANY other allergy?			
Suffer from bronchitis, asthma or ANY other chest condition?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes, or does anyone in your family?			
Bruise easily or, following a tooth extraction, surgery or injury, have you or members of your family bled unduly?			
Carry a medical warning card?			
Have any other serious illness?			
Are there any other aspects concerning your health that you think your dentist should know about?			
Do you smoke?			_____ Per Day
Do you drink alcohol?			_____ Pints / Week _____ Glasses of Wine / Week _____ Spirits / Week

Are you claiming exemption from payment of NHS charges?(please circle) YES / NO

If YES, under which category are you claiming? (please circle)

JSA / IS / HC2 / Tax Credits / Pension Credit / Child (Under 18) / Pregnant / Nursing Mum (child under 12 months)

Completed by: Self/Parent/Guardian (please circle)

SIGNATURE:..... **PRINT NAME:**..... **DATE:**.....

MEDICAL HISTORY UPDATE (For practice use only)

Have there been any changes in the patient's health, medicines, injections or tablets since the last course of treatment?

YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
Date	Date	Date	Date	Date
Sign	Sign	Sign	Sign	Sign
YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
Date	Date	Date	Date	Date
Sign	Sign	Sign	Sign	Sign