**Confidential medical questionnaire**

**We ask for information about your general health to help us treat you safely. Pleasewrite your contact details below. Answer the health questions and then sign the form. We will use this form at later visits to discuss any change to yourhealth. All information will be kept strictly confidential by the people caring for you.**

Name ............................………………………………………….............…….......................... Mr, Mrs, Miss, Ms….….......…

ADDRESS…………………………………………………….....….……………………………postcode………………....…Date of Birth ………………...……E-MAIL ADDRESS…...………...…............…………………………………………………

telephone: home……………..…….……… work……………...…………. MOBILE…………....….…………….

yourdoctor’s name, address………………………….................................…………………………………………

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occupation………………............…..……….WHERE DID YOU HEAR ABOUT US?…………....………………………

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| 1. Have you ever had rheumatic fever, a heart murmur, angina? ................................................................................................. 2. Have you ever suffered a heart attack or had heart surgery (e.g. pacemaker)? ........................................................................ 3. Do you have high blood pressure? ............................................................................................................................................ 4. Do you suffer from asthma, bronchitis or other chest condition? ............................................................................................ 5. Do you suffer from hay fever, eczema? .................................................................................................................................... 6. Are you allergic to any medicines, food or materials? ............................................................................................................. 7. Do you have arthritis? ............................................................................................................................................................... 8. Have you had jaundice, hepatitis, liver or kidney disease? ...................................................................................................... 9. Do you have fainting attacks, giddiness, blackouts or epilepsy? ............................................................................................. 10. Do you have diabetes? .............................................................................................................................................................. 11. Are you taking any medicines (Tablets, creams, injections, other)? ........................................................................................ 12. Are you taking or have you taken any steroids in the last two years? ...................................................................................... 13. Have you been hospitalized? If YES what for and when? ....................................................................................................... 14. Do you have any blood disorders (eg sickle cell anaemia)? ..................................................................................................... 15. Do you bruise easily or bleed excessively after a tooth extraction, surgery or injury? ............................................................ 16. Have you had a bad reaction to Local Anaesthetic? ................................................................................................................. 17. Do you carry a warning card? What for? .................................................................................................................................. 18. Do you smoke, or use any tobacco products, if so, how many per day? .................................................................................. 19. How many units of alcohol do you drink per week? ……………………………………............................…………............ 20. Other aspects concerning your health that you think your dentist should know about? ...................................................... 21. Are you pregnant? If you are pregnant or you think you might be, please tell your dentist.................................................................... 22. Do you have Dental Insurance? ....................... 23. Would you like to discuss any of the following treatments with your dentist:   Orthodontics (Braces)........ Whitening........ Implants........ Wrinkle treatments (eg Botox/Fillers)........  Signed ……………………..........………..........……. (patient/parent/guardian) Date ……………………...  ***Dentist Signature………………………………….*** |

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| Review Date | Changes to Medical History | Signed |
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