Personal & Medical History Questionnaire

To obtain the best and safest treatment for you, your dentist needs to know of aspects of your general health which may affect your dental treatment. Please complete this form, which your dentist will discuss fully with you before commencing treatment. If you have any questions, please ask your dentist. Please ensure that you advise us of any changes to your medical condition.

All information will be kept confidential. Thankyou

Title:	Forename(s):	
Date of Birth:	Surname:	
Address:		
		Postcode:
Telephone (home):	Telephone (work):	
Telephone (mobile):	e-mail address:	
Messages may be left: (delete as applicable)	With a family member	On an answerphone
Occupation:		
Approximate date of last dental visit?		
Name & address of your Doctor: Dr Surgery/Clinic/Health Centre		

Are you currently:	**No**	**Yes**	**If Yes, please give full details:**
Pregnant?			Due date:
Attending or receiving treatment from a Doctor, Hospital , Clinic or Alternative Therapist			
Taking any prescribed medicines from your Doctor? (tablets......particularly Bisphosphonates, ointments, injection or inhalers including HRT & contraceptives)			Names of medicines:
Using any non-prescribed, self-prescribed, alternative, herbal or recreational drugs?			
Carrying a Medical Warning Card or other MediAlert Device?			

Do you suffer from?	**No**	**Yes**	**If Yes, please give full details:**
Allergies to any medicines (eg Penicillin), substances (eg Latex) or foods?			What are you allergic to?
Hay fever or eczema?			
COPD, bronchitis, asthma or any other chest condition?			
Fainting attacks, giddiness or blackouts			
Epilepsy			Your dentist may ask more details about the history of your epilepsy, such as how often you have episodes, how long they last and information about recovery. This is to help us deal with you appropriately should you have an epileptic seizure in our practice.

Do you suffer from?	No	Yes	If Yes, please give full details:
Heart problems, angina, blood pressure problems, or had a heart attack or a stroke?			
Osteoporosis or bone tumours?			Please name condition and any medication being taken for it:
Diabetes or does anybody in your immediate family?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV & Hepatitis)?			
Cold Sores?			

Did you, as a child or since, have:	No	Yes	If Yes, please give full details:
Rheumatic Fever or Chorea (St. Vitus' Dance)?			
Liver disease (eg Jaundice, Hepatitis) or kidney disease?			
Blood tests, inoculations etc. (other than routine ones)?			
Your blood refused by the Blood Transfusion Service?			
A bad reaction to a general anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Any other serious illness?			
Heart surgery, including the fitting of a pacemaker?			
Brain surgery, surgery on a tumour or cyst of the spine, growth hormone treatment or corneal transplants?			
A close relative with Creutfeldt-Jakob disease?			

Do you (or have you in the past)?	Yes	Yes in the past	No	If yes please indicate how many / much per day and stipulate type of tobacco product used Ie: cigarettes, cigars, pipe, chewing
Smoke(d) or use(d) any other tobacco products?				

Do you:	Yes Regularly	Yes Occasionally	No Never	If yes, please indicate how many units per week on average.
Drink alcohol?				one unit of alcohol is one 125ml glass of wine or 1/2 pint of regular beer

Are there:	Yes	No	If yes, please give full details:
Any other aspects of your general health that we should know about?			
Form completed by: (delete as applicable)	Self	Parent	Guardian
Signature:			**Date:**

Medical History Updates:				
Have there been any changes in your health, medicines, injections or tablets since your last course of treatment?				
Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Date:	Date:	Date:	Date:	Date:
Signed:	Signed:	Signed:	Signed:	Signed: