QUEENSWAY DENTAL PRACTICE MEDICAL HISTORY QUESTIONNAIRE

Surname..Forename..

Address.. Postcode..................

Date of Birth...................... ....Email..

Tel no................................... Mobile....................... ....

Certain medical conditions can affect dental treatment and vice versa. Please complete this form by ticking the appropriate boxes and answering questions. All details will be strictly confidential

Do you have or have you ever suffered from:	Yes	No
Diabetes	☐	☐
Arthritis	☐	☐
Epilepsy, blackouts, giddiness or fainting	☐	☐
Rheumatic Fever	☐	☐
Chronic Bronchitis, Asthma or any other Respiratory Disease	☐	☐
Hepatitis, Jaundice, Liver or Kidney Disease	☐	☐
High blood pressure or Angina	☐	☐
Heart Disease, Heart Attack or any related complaints	☐	☐
Has had Heart/Pace-maker surgery	☐	☐
Steroid Therapy has been administered in past two years	☐	☐
Herpes, Cold Sores	☐	☐
HIV Positive	☐	☐
Any Allergies or ever had allergic reactions to Local or General Anaesthetic	☐	☐
Recently undergone any blood tests	☐	☐
Are you pregnant or have had a baby in the last 12 months delete as appropriate	☐	☐
Undergone a joint replacement operation	☐	☐
Are you currently undergoing any Medical Treatment	☐	☐
At present undertaking medication (**PLEASE LIST BELOW**)	☐	☐
Undergone hospitalisation that may affect dental care	☐	☐
Any other serious illness or related medical condition	☐	☐
If you smoke, what is your average per week	☐	☐
What is average weekly consumption of alcohol	☐	☐
GP Name & Address:		
Please list any medication:		
If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dentist.		

Patient's Signature...Date..............