Surname (Mr/Mrs/Miss/Ms) ....

Forename ....

Address ....

Postcode .... Email ....

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

Date of Birth .... Occupation ....

I give my consent to my contact details being used for the following: (please tick)

Practice Communications (Appt reminders, etc.) .... email ☐ sms ☐

Marketing Communications .... email ☐ sms ☐

Certain medical conditions can affect dental treatment and vice versa

Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential	yes	no
Do you have or have you ever suffered from:		
Rheumatic fever?	☐	☐
Any heart complaint. heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Any other serious illness?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you allergic to **any** medicine, tablets, substances or latex? (list below)	☐	☐
at present taking any medicine or tablets? (list below in notes)	☐	☐
pregnant	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
been treated with hydro-cortisone or corticosteroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or **tell the dentist** if you are HIV positive	☐	☐

What is your average weekly consumption of alcohol? ....

If you smoke, what is your average per week? ....

If 'yes' to any questions please supply details in 'Notes' below

Name and address of your doctor:

....

....

....

....

Notes: ....

....

....

....

....

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

Patients signature: .... **Date** ....

Ref: Medical History Questionnaire 02/18

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