QUEEN STREET DENTAL

Dental and Medical Questionnaire

It is important to know details about your medical history as these could affect the success of your oral health care.
The information you provide is confidential and will be handled in accordance with our privacy policy.

Name _____ Title _____ DOB _____

	Yes	No
Have you been in hospital in the last twelve months?		
Are you being treated by a doctor at present?		
Who is your medical practitioner?		
Are you taking any tablets or medicines (prescribed or over-the-counter) at present?		
Please list:		
Have you been advised by your doctor to routinely take antibiotics cover before dental treatment?		
Have you had any abnormal reactions to local or general anaesthesia?		
Do you smoke?		
Do you take some alcohol each day?		

Please list any drugs or medicines you are allergic to: _____

Please list any known allergies (including latex): _____

Do you have, or have you ever had, any of the following medical conditions? (please tick the appropriate box(es))

	Yes	No
Heart complaint		
High or low blood pressure		
Heart murmur		
Cardiac pacemaker/Prosthetic implant eg artificial hip		
Rheumatic fever		
Anaemia, leukaemia or other blood diseases		
Excessive bleeding		
Hepatitis or other liver disease		
Kidney disease		
Asthma, bronchitis, emphysema or other lung diseases		
Diabetes		
Thyroid disease		

	Yes	No
Epilepsy		
Stroke		
Nervous condition		
Stomach or digestive condition		
Steroid therapy		
Radiation therapy		
Contact with HIV/AIDS virus		
Are you pregnant? (females only)		
Any other condition(s) (please list)		

Contact in case of emergency _____ Telephone _____ Relationship _____

I have confidential medical information that I do not wish to write down. I would prefer to speak to a dentist about this (please tick box) ☐

Signed _____ / /

Dentist's signature _____ / /

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