



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?	<input type="checkbox"/>	<input type="checkbox"/>
Are you being treated by a doctor at present?	<input type="checkbox"/>	<input type="checkbox"/>

Who is your medical practitioner? _____

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Are you taking any tablets or medicines (prescribed or over-the-counter) at present? _____

Please list: _____

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Have you been advised by your doctor to routinely take antibiotics cover before dental treatment?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Have you had any abnormal reactions to local or general anaesthesia?

Do you smoke? _____

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

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		Yes	No
Heart complaint	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous condition	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac pacemaker/Prosthetic implant eg artificial hip	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or digestive condition	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Steroid therapy	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia, leukaemia or other blood diseases	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Contact with HIV/AIDS virus	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? (females only)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Any other condition(s) (please list)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, bronchitis, emphysema or other lung diseases	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>			

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 _____ / / _____