Queen Street Dental

ExperienceCare

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 _____

Have you been in hospital in the last twelve months or are you being treated by a doctor at present? ☐ Yes ☐ No

Who is your medical practitioner? _____

Are you taking any tablets or medicines (prescribed or over-the-counter) at present? ☐ Yes ☐ No

Please list: _____

Have you had any abnormal reactions to local or general anaesthesia? ☐ Yes ☐ No

Do you take some alcohol each day? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Please list any known allergies (including drugs): _____

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

Heart complaint ☐ Yes ☐ No

High/Low Blood Pressure ☐ Yes ☐ No

Cardiac Pacemaker or other prosthetic implant eg valve, hip, knee etc ☐ Yes ☐ No

Bleeding Disorders, Excessive Bleeding, Deep Vein Thrombosis ☐ Yes ☐ No

Anticoagulation Therapy ☐ Yes ☐ No

Asthma, Bronchitis, Emphysema ☐ Yes ☐ No

Sleep Apnoea/CPAP ☐ Yes ☐ No

Reflux/GORD ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Thyroid Disease ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Steroid Therapy ☐ Yes ☐ No

Radiation/Chemotherapy ☐ Yes ☐ No

Anxiety/Depression ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Are you Pregnant ☐ Yes ☐ No

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): ☐ Yes

Signed _____ **Date** _____

Dentist Signature _____ **Date** _____

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