CONFIDENTIAL **Pt number - Initial**

Medical History Questionnaire V5

SURNAME :(Mst, Mr,Miss,Mrs,Ms).....……..
FORENAME:…… Date of Birth ....……
Address:…….……
…… Post Code: ……..
Telephone:(Home)……..Work:…….....
Mobile:……Email:……
When was your last Dental Visit .....
Doctor (GP), Name, Address, Telephone:……..……....
……...….
……Post Code:……..…

PLEASE CIRCLE AS APPROPRIATE →

Are you currently pregnant?	Yes/No
Are you currently receiving treatment from a doctor, hospital or a clinic?	Yes/No
Are you currently taking any prescribed medications? (e.g. Tablets, Ointments, Inhalers) – list below	Yes/No
Do you carry a medical warning card?	Yes/No
Do you suffer with allergies from any medicines/foods? (e.g. Penicillin,Latex,Rubber)	Yes/No
Do you suffer with Hayfever or Eczema?	Yes/No
Do you suffer with Bronchitis, Asthma or other chest conditions?	Yes/No
Do you suffer with fainting attacks, giddiness, blackouts or Epilepsy?	Yes/No
Do you suffer with heart problems, angina and blood pressure? Have you ever had a stroke?	Yes/No
Are you Diabetic? (Does anyone in your family suffer with Diabetes?)	Yes/No
Do you suffer with Arthritis?	Yes/No
Do you suffer with bruising or persistent bleeding following injury, tooth extraction or surgery?	Yes/No
Do you suffer with any infectious diseases? (Including HIV/Hepatitis?)	Yes/No
Have you ever had liver disease? (E.g. Jaundice/Hepatitis?) Or Kidney infections?	Yes/No
Have you ever had rheumatic fever?	Yes/No
Have you ever had a serious illness?	Yes/No
Have you ever had blood refused from the Blood Transfusion Service?	Yes/No
Have you ever had a bad reaction to local or general anaesthetic?	Yes/No
Have you ever had a hip or joint replacement or other implant?	Yes/No
Have you ever had treatment that has required you to be in hospital?	Yes/No
Have you ever had heart surgery, or a pacemaker fitted?	Yes/No
Do you smoke any tobacco products (pan, gutkha, supari) now(or did you in the past)?	Yes/No
Do you regularly drink more than 14 units of alcohol per week?	Yes/No
Have you ever had a bad experience or feel anxious about the dentist?	Yes/No
If there any information which you feel your dentist must know? Please state below: Self Prescribed medications:	Yes/No
Are you happy with your smile?	Yes/No

Patient Signature: Date: **Dentist** Signature: Date:

LIST MEDICATION / ANY OTHER COMMENTS:

Diet Analysis:

Do you use a manual or electric toothbrush?.....
Do you floss or use any inter-dental device? Please circle YES / NO
If so, how often and which one.....
Which drink do you commonly have between meals?
How much sugar do you consume in your hot drink?