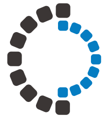

bite dentistry

confidential medical history questionnaire

We ask you for information about your general health to help us treat you safely.
Please write your contact details below, answer the health questions and then sign the form on the back page. We will use this form at later visits to discuss any changes in your general health.
All information will be kept strictly confidential by the people caring for you.

Surname .... **Title** ....

Forenames ....

Sex Male/Female .... **Date of birth** day.......... month.......... year..............

Address ....

....

Postcode ....

Telephone home .... work ....

Email ....

Occupation ....

Date of last dental treatment day.......... month.......... year..............

Doctor's name ....

Doctor's address ....

....

Doctor's telephone ....

Are you currently	Y	N	Give details
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)?			
Carrying a medical warning card?			
Pregnant?			

Do you suffer from	Y	N	Give details
Allergies to any medicines (eg penicillin), substances (eg latex/rubber) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts, epilepsy?			
Heart problems, angina, blood pressure problems, or stroke?			
Diabetes (or does anyone in your family)?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV and hepatitis)?			

Did you, as a child or since, have:	Y	N	Give details
Rheumatic fever or chorea?			
Liver disease (e.g. jaundice, hepatitis) or kidney disease?			
Any other serious illness?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in the hospital?			
Heart surgery?			

Drinking	Units / week
How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif.)	*Units per week*

Smoking and chewing	Y	N	In past	Quantity
Do you smoke any tobacco products now (or did you in the past)?				*times per day*
Do you chew tobacco, pan, use gutkha or supari now (or did you in the past)?				*times per day*

Please give any other details which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)

Completed by (please tick) Self .... Parent .... Guardian ....

Signature

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	No change	Changes	Patient's initials

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Additional notes

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