CONFIDENTIAL MEDICAL HISTORY

In order to allow us to treat you safely it is essential that you complete this medical questionnaire and advise the dentist of any other problems which may affect your treatment.

NAME_____ SURNAME_____ DATE OF BIRTH _____

ADDRESS_____

PHONE: (home) _____ (mobile)_____

EMAIL_____ OCCUPATION_____

How Long Since Your Last Dental Treatment?_____ PPS Number:_____

Medical Doctor's Name_____

	Yes	No	Comments
1. Are you expecting a baby (please advise due date)			
2. Attending or receiving treatment from your doctor, hospital, clinic or specialist?			
3. Taking any medicines (tablets, injections, contraceptive pill)?			
4. Taking or have taken steroids or bisphosphonates in the past two years?-give details			
5. Do you have any allergies? (eg Penicillin, Latex)			
Have you: 1. Had rheumatic fever?			
2. Had liver, kidney disease, hepatitis or HIV?			
3. Ever been told you have a heart murmur or heart problem, angina, blood pressure, heart attack?			
4. Had a bad reaction to a general or local anaesthetic?			
5. Had a joint replacement?			
6. Been hospitalised? If YES, what for and when?			
7. Have you ever had a problem following an extraction, e.g. Bleeding, dry socket?			
Do you : 1. Smoke?			
2. Have a pacemaker, or have you had any form of heart surgery?			
3. Suffer from bronchitis, asthma or other chest condition?			
4. Have fainting attacks, giddiness, blackouts or epilepsy?			
5. Have diabetes?			
6. Bruise easily or following a tooth extraction, surgery or injury have you or your family bled so as to cause you to be worried?			
7. Suffer from any viral infections? (hepatitis-cold sores etc.)			

Patient Signature _____ ***Date*** _____