Medical History Questionnaire

This provides the dentist with important information required for your Dental treatment and Oral Health Care.

YOUR DETAILS (PLEASE USE CAPITAL LETTERS) :

Title______________

Surname: __________________________________ **Forename:** _____________________________

Home Address:______________________________ **Date of Birth:** ___________________________

____ **Home Phone:** ___________________________

____ **Mobile Phone:**___________________________

____ **Email:** __________________________________

Occupation:________________________________ **NHS No:** ________________________________

EMERGENCY CONTACT DETAILS: (Details of someone we can contact on your behalf if needed)

Name: ____________________________________ **Phone Number**:____________________________

Relationship: _______________________________ **Are they a patient at the practice? Yes No**

SOCIAL HISTORY

Do you drink alcohol? Yes No If yes, how many units a week ___________

Do you smoke? Yes No If yes, how many a day _________________

On a scale of 1-10 (10 being very anxious), how **anxious** are you when receiving dental treatment?

1 2 3 4 5 6 7 8 9 10

DETAILS OF GMP:

GMP Practice Name ____

GP Address: ____

Telephone ____

Most medical conditions can affect dental health and any treatment we may provide you. It is important that our records are kept up to date with any changes to your health and general well-being.
Please complete the form overleaf and answer ALL questions asked. All details you provide will be strictly confidential.

PTO

MEDICAL HISTORY

Do you, or have you ever suffered from any of the following:

Please tick yes or no in each box				
Heart Conditions:		***Yes***	***No***	***Details please***
	Rheumatic fever			
	Heart Surgery			
	High/low Blood Pressure			
	Pacemaker			
	Angina			
	Heart Murmur			
	Any other heart conditions			
Blood Conditions:		***Yes***	***No***	***Details please***
	Hepatitis A,B,C, D			
	HIV/AIDS			
	Anaemia			
	Sickle Cell			
	Haemophilia			
	Any other blood conditions			
Chest Conditions:		***Yes***	***No***	***Details please***
	Bronchitis			
	Cystic fibrosis			
	Asthma			
	COPD			
	Any other breathing/chest conditions			
Other Conditions:		***Yes***	***No***	***Details please***
	Diabetes			
	Epilepsy/fainting attacks			
	Cancer/radiotherapy			
	Osteoporosis			
	Cold sores			
	Anxiety or Depression			
	Liver Disease			
	Kidney Disease			
Allergies		***Yes***	***No***	***Details please***
	Penicillin			
	Hayfever			
	Latex			
	Medicines			
	Other			

Are you pregnant? Yes No Not applicable

Do you take any **regular medications**? Yes No (If yes, please give details below)

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(If you are on multiple medications, please provide us with a list/repeat prescription which can be scanned)

Declaration: I can confirm all details are correct as per my knowledge

Signed: ________________________________ **Date:**

(If patient is 16 or younger, parent or guardian must sign)