# Welcome

lancing dental practice

## Medical History Questionnaire

*Please **answer all questions thoroughly**, providing as much detailed information where necessary. If you are unsure of any of the questions, please speak to your Dentist. Please **keep us updated** on any changes to your medical circumstances.*

### Personal Details

**Title:** **Mr / Mrs / Miss / Ms / Other:** ..... **Date of birth:** .....

**First Name:** ..... **Surname:** .....

**Address:** .....

..... **Postcode:** .....

**Telephone:** **Home:** ..... **Mobile:** .....

**Work:** ..... **Occupation:** .....

**Email:** .....

### Medical History

| | Yes | No |
|---|---|---|
| • Do you have, or have you suffered from **rheumatic fever**? ..... | ☐ | ☐ |
| • Do you have, or have you ever had a **heart complaint**? ..... | ☐ | ☐ |
| • Have you had **heart surgery**? ..... | ☐ | ☐ |
| • Have you ever suffered a **stroke**? ..... | ☐ | ☐ |
| • Do you have **high blood pressure**? ..... | ☐ | ☐ |
| • Do you have **diabetes**? ..... | ☐ | ☐ |
| • Do you have **epilepsy** or **fainting attacks**? ..... | ☐ | ☐ |
| • Do you have any respiratory illnesses such as **asthma, chronic bronchitis** or **COPD**?..... | ☐ | ☐ |
| • Do you have, or have suffered from **hepatitis**? ..... | ☐ | ☐ |
| • Do you suffer from **excessive bleeding**? ..... | ☐ | ☐ |
| • Do you have any other **illnesses**? *please state here:* ..... | ☐ | ☐ |
| • Have you ever been notified that **you are at increased risk** of **Creutzfeldt-Jakob Disease (CJD)** or **variant Creutzfeldt-Jakob Disease (vCJD)**? ..... | ☐ | ☐ |
| • Do you carry a **medical warning card**? ..... | ☐ | ☐ |
| • **In the past 2 years** have you been treated with **hydro-cortisone** or **corticosteriods**? ..... | ☐ | ☐ |
| • Have you ever had a **joint replacement** operation? ..... ..... | ☐ | ☐ |
| • *(if applicable)* Are you an **expectant mother**? ..... | ☐ | ☐ |
| • **Are you allergic** to any medicine, tablets, substances or latex? ..... | ☐ | ☐ |

If **yes**, please list here:

1. ..... 2. .....

| | Yes | No |
|---|---|---|
| • **Are you at present taking** any **medicine** or **tablets**? ..... | ☐ | ☐ |

If **yes**, please list here:

1. ..... 5. .....
2. ..... 6. .....
3. ..... 7. .....
4. ..... 8. .....

| | Yes | No |
|---|---|---|
| • **In the past 2 years** have you undergone any **operations**? ..... | ☐ | ☐ |

If **yes**, please provide details here:

.....

***your details will be kept private and confidential***

continued overleaf

| | Yes | No |
|---|---|---|
| • Are you **HIV positive**? ..... | ☐ | ☐ |
| • What is your average weekly **consumption of alcohol** in units? ..... | ☐ units | |
| • Do you, or did you used to **smoke** regularly?..... | ☐ | ☐ |

If ***yes***, please write how many on average a day, and for how many years: ☐ day ☐ years

### Any other relevant information

*Is there any **other information** we should be aware of?*

.....

.....

### Your Doctor's details

**Name of your Doctor:** .....

**Address:** .....

..... **Telephone Number:** .....

### In the event of an emergency please contact

**Name of contact:** .....

**Relationship to you:** ..... **Telephone Number:** .....

### Declaration

I hereby confirm that the information I have provided is accurate and to the best of my knowledge.

**Patient / Guardian's signature** ..... **Date:** .....

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### Updates

Please check that all the information on this form is still correct and record any changes below.

| **Changes advised:** | **Date of Review** |
|---|---|
| | |
| | **Patient's signature** |

| **Changes advised:** | **Date of Review** |
|---|---|
| | |
| | **Patient's signature** |

| **Changes advised:** | **Date of Review** |
|---|---|
| | |
| | **Patient's signature** |

| **Changes advised:** | **Date of Review** |
|---|---|
| | |
| | **Patient's signature** |

***your details will be kept private and confidential***