Confidential Medical History Questionnaire

Personal Details

Title: D.O.B: Gender:

Forename: Surname:

Address:

Post Code:

Mobile No.: Home No.:

Email address:

We process personal data for the purposes of providing optimum dental healthcare, sending important updates to you, providing you with news about treatments and what is happening at the practice and informing you about our services. You can withdraw your consent at any time.

The practice can contact me about my treatment: ☐ By text ☐ By email

Medical History – Do you have, or have you had, any of the following? (Please tick yes or no)

	Yes	No		Yes	No
Cold Sores			Arthritis		
Rheumatic fever			Liver or Kidney problems		
Heart disease / Stroke			A bad reaction to general or local anesthetic		
Diabetes			Tuberculosis		
Bronchitis / Asthma / C.O.P.D			Treatment that required you to stay in hospital: (State)		
Epilepsy / Seizures					
Hepatitis					
Excessive Bleeding			Women Only		
High Blood Pressure			Are you currently breastfeeding?		
Headaches / Migraines			Are you currently pregnant?		

Are you allergic to any medicines, tablets, substances or latex? If so, please state: which:

Do you drink alcohol? If so, please state how many units you drink on average per week:

Do you smoke? If so, please state how many cigarettes you smoke on average per week:

Are you currently taking any medication? If so please state:

Is there anything else that you think we need to know?

Please provide your G.P's Name and Address:

Date: Signed: