PATIENT MEDICAL QUESTIONAIRE		
WHAT IS YOUR PROFESSION?		
	YES	**NO**
ARE YOU CURRENTLY RECEIVING TREATMENT FROM A DOCTOR, HOSPITAL, OR CLINIC?		
HAVE YOU EVER HAD A HEART MURMUR OR BEEN TOLD YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT?		
ARE YOU CARRYING A MEDICAL WARNING CARD? DO YOU SUFFER FROM ALLERGIES TO ANY MEDICINES (EG PENICILLIN), SUBSTANCES (EG LATEX/RUBBER? OR FOODS)?		
DO YOU SUFFER FROM HAY FEVER OR ECZEMA?		
DO YOU SUFFER FROM BRONCHITIS, ASTHMA OR OTHER CHEST CONDITIONS?		
DO YOU SUFFER FROM FAINTING ATTACKS, GIDDINESS, BLACKOUTS OR EPILEPSY?		
DO YOU SUFFER FROM HEART PROBLEMS, ANGINA, BLOOD PRESSURE, OR STROKE?		
ARE YOU DIABETIC (OR IS ANYONE IN YOUR FAMILY)?		
DO YOU SUFFER FROM ARTHRITIS?		
DO YOU SUFFER FROM BRUISING OR PERSISTENT BLEEDING FOLLOWING INJURY, TOOTH EXTRACTION OR SURGERY?		
DO YOU SUFFER FROM ANY INFECTIOUS DISEASES (INCLUDING HIV AND HEPATITIS)?		
HAVE YOU EVER HAD RHEUMATIC FEVER OR CHOREA?		
HAVE YOU EVER HAD LIVER DISEASE (EG JAUNDICE, HEPATITIS) OR KIDNEY DISEASE?		
HAVE YOU EVER HAD ANY OTHER SERIOUS ILLNESS?		
HAVE YOU EVER HAD BLOOD REFUSED FROM THE BLOOD TRANSFUSION SERVICE?		
HAVE YOU EVER HAD A BAD REACTION TO GENERAL OR LOCAL ANAESTHETIC?		
HAVE YOU EVER HAD A JOINT REPLACEMENT OR OTHER IMPLANT?		
HAVE YOU EVER HAD TREATMENT THAT REQUIRED YOU TO BE IN HOSPITAL?		
HAVE YOU EVER HAD HEART SURGERY?		
HAVE YOU EVER HAD BRAIN SURGERY?		
DID YOU RECEIVE GROWTH TREATMENT BEFORE THE MID 1980'S?		
DO YOU HAVE ANY CLOSE RELATIVES (PARENT, SIBLING, CHILD, GRANDPARENT, OR GRANDCHILD WITH CREUTZFELDT JAKOB DISEASE)?		
DO YOU REGULARLY DRINK MORE THAN 14 OF ALCOHOL PER WEEK?		
ARE YOU PREGNANT? AND IF SO, HOW MANY WEEKS?		

DO YOU SMOKE OR CHEW ANY TOBACCO PRODUCTS, PAN, USE GUTKHA OR SUPARI (OR DID YOU IN THE PAST)		
IS THERE ANY OTHER INFORMATION WHICH YOUR DENTIST MIGHT NEED TO KNOW, (EG SELF-PRESCRIBED MEDICINES (EG ASPIRIN)?		
ARE YOU CURRENTLY TAKING ANY PRESCRIBED MEDICINES (EG TABLETS, OINTMENTS, OR INHALERS, INCLUDING CONTRACEPTIVES AND HORMONE REPLACEMENT THERAPY?)		
PLEASE LIST YOUR MEDICATION BELOW		

NAME……

MOBILE ……

REGISTERED GP & ADDRESS……

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DATE OF BIRTH ……

SIGNATURE DATE:

Patient Confidentiality

We take patient confidentiality very seriously. Please would you indicate whether you are happy for us to contact you on your mobile or leave a message on your answer machine at home, regarding your treatment or appointments?

Yes/ No

Signed …… Date ……..