Medical History Questionnaire

Last name	First name	Title
Address		Postcode
Telephone numbers: Home	Work	Mobile
Date of birth	Email	
GP name	How did you hear about us?	
GP address	Referred (name)	NHS choices
	Website	Other
Occupation		
Emergency contacts: Name	Tel	

	Please tick		
Are you attending or receiving treatment from a doctor/hospital/ clinic?	Y	N	Details
Have you had any operations or serious illnesses?	Y	N	Details
Are you taking any medicines or tablets?	Y	N	Please list
Are you taking or have you recently taken any form of steroid?	Y	N	Details
Are you allergic to any medicines, foods? e.g penicillin, latex	Y	N	Details
Have you had rheumatic fever or chorea?	Y	N	Details
Have you been told you have a heart murmur or heart problem, angina, abnormal blood pressure, pacemaker or have you had any form of heart surgery?	Y	N	Details
Have you had a bad reaction to a local or general anaesthetic?	Y	N	Details
Do you suffer from arthritis, osteoporosis, bone disease or take bisphophonates?	Y	N	Details
Have you had jaundice, liver or kidney disease or hepatitis?	Y	N	Details
Do you have fainting attacks, giddiness, blackouts or epilepsy?	Y	N	Details
Do you suffer from bronchitis, asthma or other chest problems?	Y	N	Details
Do you have any stomach and intestine problems eg gastric reflux, ulcers, colitis?	Y	N	Details
Do you (or anyone in your family) suffer from diabetes?	Y	N	Details
Do you bruise easily or suffer from abnormal beeding after a tooth extraction?	Y	N	Details
Could you possibly have contacted HIV, hepatitis, TB or CJD?	Y	N	Details
Are you pregnant, or have you had a baby in the last year? Please give details.	Y	N	Details

All the information you have provided will be strictly private and confidential and will not shared without your consent

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	Please tick	
Do you smoke any tobacco products now or in the past?	Y N	How many per day?
If you smoked in the past, when did you stop?	Y N	Details
Do you chew tobacco, pan, use gutkha or supari now or in the past?	Y N	How many times per day?
Do you drink alcohol?	Y N	How many units per week?
Are you nervous or anxious about visiting the dentist?	Y N	Details
When did you last see a dentist? Where?	Y N	Details
Is there anything about your teeth you are not happy with?	Y N	Details
Have you had any discomfort in your teeth recently?	Y N	Details
Are you aware of grinding or clenching your teeth?	Y N	Details
Do your jaw joints ever hurt, click or lock?	Y N	Details
Do your gums bleed easily?	Y N	Details
Do you suffer from bad breath or taste?	Y N	Details
Do you suffer from sensitive teeth?	Y N	Details

Would you like to know more about?

☐ Teeth whitening ☐ Cosmetic Dentistry ☐ Replacing missing teeth ☐ Implants ☐ Dentures ☐ Teeth straightening

☐ Wrinkle reduction

Do you have any concerns that you would like your dentist to be aware of?	Y N	Details
Is there anything else regarding your health your dentist should know?	Y N	Details

Signature	Date	Self / parent / guardian
Signature of dentist	Date checked	

Date	Any changes since your last visit	Initial

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