Clayhall Dental Care

Confidential Medical History Questionnaire

Full Name (Mr/Mrs/Miss/Ms)	**Address:** **Post Code:**
Date of Birth: **NHS Number:** **Occupation:**	**Telephone No Home:** **Mobile:** **Work:** **Email:**

Please reply to the questions below as accurately as possible. If you are in any doubt about specific questions, please do not hesitate to ask.

1	Are you currently undergoing any medical treatment? Details:	Yes/ No
2	Do you now have or have had any of the following? a) Heart Disease b) Rheumatic Fever c) Hepatitis d) Jaundice e) Epilepsy f) Diabetes g) Increased blood pressure h) Anaemia i) Asthma, hayfever or eczema j) Hereditary or acquired bleeding problems k) Osteoporosis l) Other serious illness? <u>Please specify</u>:	 Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No
3	Have you experienced allergies or reactions to: a) Penicillin or other antibiotics? b) Other forms of medicine, tablets or substances? c) Latex? d) Local anaesthetic? <u>Please give details</u>:	 Yes/ No Yes/ No Yes/ No
4	Are you currently taking any form of medication? If you are, please indicate what medication you are taking: - - - - - Are you taking Bisphosphonates and if so, *oral or IV (injection)*?	Yes/ No Yes/No

5	In the past 5 years have you been treated with any of the following: a) Cortisone (hydrocortisone, Prednisalone, ACTH)? b) Blood Diluting medicine? c) Antidepressants? d) Other forms of medicine, tablets, injections, etc? e) Radiotherapy to the head and/or neck area?	Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No
6	Do you smoke or have you smoked in the last 5 years? If yes, how much on average per day: _____	Yes/ No
7	Alcohol Consumption: _____ units per week	
8	Ladies, are you expecting a baby? If yes, please specify due date:	Yes/ No
9	Are you the mother of a child under 12 months? Date baby born: _____	Yes/ No
10	Are you in receipt of any benefits that exempt you from NHS charges, if so what benefit?	Yes/No
11	Do you have Dental Insurance? If so with whom?	Yes/ No
12	New Patients: How did you get to hear about us? _____ When was your last visit to a dentist? _____	

Signed: _____ Date: _____

NAME OF GP: _____ TEL: _____

ADDRESS : _____

MEDICAL HISTORY UPDATES:

PATIENT SIGNATURE: _____ DATE CHECKED: _____

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