

Bore Street Dental Practice Ltd.

24/26 Bore Street, Lichfield, WS13 6LL Tel: 01543 262092

Medical History Questionnaire.

Ref.....

Surname(Mr/Mrs/Miss/Ms) Forename

Address

..... Postcode

Tel.No.(home) Tel.No.(business)

Date of Birth Occupation

Certain medical conditions can affect dental treatment and vice versa.

Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential.

Do you have or have you suffered from (yes) (No)

Rheumatic fever? (yes) (No)

Infective Endocarditis? (yes) (No)

Any other heart complaint (including heart murmur)? (yes) (No)

High blood pressure? (yes) (No)

Diabetes? (yes) (No)

Epilepsy? (yes) (No)

Chronic Bronchitis? (yes) (No)

Asthma? (yes) (No)

Hepatitis? (yes) (No)

Excessive bleeding from cuts/bleeding disorders? (yes) (No)

Any other serious illness, e.g. Malignancy? (yes) (No)

Are you at present taking any medicines or tablets?(list overleaf) (yes) (No)

Are you ALLERGIC to any medicines or tablets? (list overleaf) (yes) (No)

Have you in the last 2 years been treated with hydro-cortisone or steroids (yes) (No)

Have you undergone any operations in the last 2 years? (yes) (No)

Are you pregnant? (yes) (No)

Are you the mother of a child under 12months old? (yes) (No)

Are you HIV positive? (yes) (No)

If you smoke – what is your daily average?

Please give details of Doctor - Name Practice

If you are not sure of the questions please ask the dentist.

Patients signature

Date