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 .....**

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MEDICAL HISTORY REVIEW

Has your medical history changed in any way from overleaf?

Yes	No	Signature	Date

NOTES:

School attended (please complete if in full-time education)
…….
Name and address of Doctor……..
…….……

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

Patients signature **……** **Date** **……**