CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

(All details given are treated as strictly confidential)

Mr/Mrs/Miss/Ms/Other (Please Circle) Date of Birth: ………………….…..

Last Name: ………………………………………First Name: …………………………………..
Doctor’s Surgery Name & Address:

……………………………………………………………………………………………………

Surgery Telephone No (If known): ……………………………………………………………..

In the event of you suffering a medical emergency, while you are in the Practice, we would like your permission to take whatever action is appropriate.

Next of kin (Name & Contact Number): ……………………………………………………….

Relationship to you: ……………………………………

<u>Please tick the box to confirm you agree to this. ☐</u>

If you have a disability, impairment or sensory loss, do you require assistance or information in an alternative format when visiting the practice?
(If “yes” please give details regarding assistance and format of information)

…………………………………………………………………………………………………….

ARE YOU?

Currently receiving treatment from a doctor, hospital or clinic..........................Yes/No

Taking any prescribed medication? <u>(if “yes” please give details</u>)......................Yes/No

……………………………………………………………………………………………

Carrying a medical warning card? (<u>if “yes” please give details</u>) ....Yes/No

……………………………………………………………………………………………..

Pregnant or possibly pregnant? ....Yes/No

DO YOU SUFFER FROM? (<u>Please circle as appropriate</u>)

Bronchitis	**Chest condition**	**Eczema**	**Arthritis**
Asthma	**Hayfever**	**Diabetes**	**Cold Sores**

Any other serious illness or infectious diseases? (Including Hepatitis or HIV)

…………………………………………………………………………………………… Yes/No

Jaw / TMJ disorder/ Bone or Joint Disease?.. Yes/No

Heart Complaint including Angina, Stroke or High/ Low Blood Pressure

(<u>Please give details</u>)..

Continued overleaf

DO YOU SUFFER FROM? (Please circle as appropriate)

Migraine **Headaches** **Fainting Attacks** **Epilepsy**

Giddiness **Blackouts** **Mental Health** **Anxiety**

Bruising or persistent bleeding following injury, tooth extraction or surgery

………………………………………………………………………………………………….

Allergies to medicines ie penicillin (Please give details) …………………………………

………………………………………………………………………………………………….

Allergies to substances ie latex or foods (Please give details)

…………………………………………………………………………………………………

HAVE YOU HAD?

Liver or Kidney disease? (eg Jaundice or Hepatitis) ....Yes/No

Blood refused by the Blood Transfusion Service? ....Yes/No

……………………………………………………………………………………………

A bad reaction to general or local anaesthetic?...Yes/No

A heart pacemaker or replacement valve? ....Yes/No

Brain surgery prior to 1992? ....Yes/No

Growth hormone treatment before 1982?...Yes/No

A blood relative (parent, child, grandparent, grandchild) suffer with

Familial Creutzfeldt Jakob Disease (CJD)?...Yes/No

Human Papilloma Virus (HPV)……………………………………………………………….Yes/No

Covid 19 ……………………………………………………………………………………..Yes / No

SMOKING

Do you smoke any tobacco products? **YES / NO / IN THE PAST**

If yes how many times per day …………

Do you chew tobacco, pan, use gutkha or supari ? **YES / NO / IN THE PAST**

If yes how many times per day …………

Do you Vape / use electronic cigarettes? **YES / NO / IN THE PAST**

DRINKING

Approximately how many units of alcohol do you drink a week? ……… **units**
(One unit is ½ pint of lager, glass of wine or 1 measure of spirit)

Please give details of anything else you feel your dentist may need to be aware of with regard to your general health

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Patient Signature ……………………………