brighton white

Medical history questionnaire

(Mr/Mrs/Miss/Ms/Dr)
Forename.....Surname.....

Address.....
..... Postcode.....
Telephone no. (Home/work).....(Mobile).....

Email.....
Date of Birth.....
Do you pay for your Dental treatment?(If no What Exemption?).....
Name & Address of your doctor .....
.....

Please Circle yes or no to the following questions, if answering yes please give details below.

Have you ever been hospitalized or had a major operation?..... **Yes/No**
.....
Have you ever had a serious head or neck injury?..... **Yes/No**
Are you taking any medications, pills or drugs?..... **Yes/No**
If Yes, please give details.....
.....
Do you smoke?.....**Yes/No**
Do you drink alcohol?.....**Yes/No**
Do you use controlled substances?.....**Yes/No**
Pregnant/Trying to get pregnant? Nursing?.....**Yes/No**
Do you have any allergies?.....**Yes/No**
If Yes, what allergy?.....
Do you have or have you ever suffered from Rheumatic fever?..... **Yes/ No**
Any Heart complaints, heart surgery or stroke? ..... **Yes/No**
If Yes, please give details.....
Do you suffer from Diabetes?.....**Yes/No**
If Yes, Type 1 or 2? (Please circle).
Epilepsy or fainting attacks? ..... **Yes/No**
Do you have Chronic Bronchitis or Asthma?..... **Yes/No**
Do you suffer with Excessive Bleeding..... **Yes/No**
Do you have High or Low blood pressure?.....**Yes/No**
If Yes, do you have High or Low blood pressure?.....
Any other serious illness?.....**Yes/No**
If Yes, please give details.....
Do you carry a medical warning card?.....**Yes/No**
Do you have HIV/Hep B or Hep C?.....**Yes/No**
If Yes, Do you have HIV/Hep B or C
Have you ever had a joint or hip replacement?.....**Yes/No**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health and it is my responsibility to inform the dental surgeon of any changes in my medical status.

Patient or guardians Signature.....Date.....