

Patient Name

D.O.B.

Address

Telephone No.

Email

Patient No.

Sex

Hygienist

Last Medical Exam at Surgery

Dentist

GP Details

Medical Questions on File

Medical Questions	Tick if Yes	Notes
Are you attending or receiving treatment from a Doctor, Hospital or Clinic?	<input type="checkbox"/>	
Are you taking any medicines from your doctor (tablets, creams, ointments, injections, other)	<input type="checkbox"/>	
Are you taking or have you taken steroids in the last 2 years?	<input type="checkbox"/>	
Are you allergic to any medicines, food or materials?	<input type="checkbox"/>	
Have you had Rheumatic Fever or Cholera (ST VITUS DANCE)?	<input type="checkbox"/>	
Have you had Jaundice, Liver, Kidney Disease or Hepatitis?	<input type="checkbox"/>	
Have you ever been told you have a heart murmur, heart problems, angina, blood pressure or heart attack?	<input type="checkbox"/>	
Have you had any blood tests, inoculations, etc?	<input type="checkbox"/>	
Have you had your blood refused by the blood transfusion service?	<input type="checkbox"/>	
Have you had a bad reaction to general or local anaesthetic?	<input type="checkbox"/>	
Have you had a joint replacement?	<input type="checkbox"/>	
Have you been hospitalised? If "YES", what for and when?	<input type="checkbox"/>	
Do you have arthritis?	<input type="checkbox"/>	
Do you have a pacemaker, or any form of heart surgery?	<input type="checkbox"/>	
Do you suffer from hay fever, eczema or any other allergy?	<input type="checkbox"/>	
Do you suffer with bronchitis, asthma or any other chest conditions?	<input type="checkbox"/>	
Do you have fainting attacks, giddiness, blackouts or epilepsy?	<input type="checkbox"/>	
Do you have diabetes or does anyone in your family?	<input type="checkbox"/>	
Do you bruise easily or following a tooth extraction, surgery or injury, have you or your family bled so as to cause you to be worried, bleeding disorders?	<input type="checkbox"/>	

Do you carry a warning card?	<input type="checkbox"/>	
Do you ever get cold sores?	<input type="checkbox"/>	
Do you smoke (or have you done so in the past)? If so how many tobacco products do you use per day/week?	<input type="checkbox"/>	
Do you drink alcohol? If yes then how many units per week do you consume?	<input type="checkbox"/>	
Do you chew tobacco pan or use supari currently (or have done so in the past)?	<input type="checkbox"/>	
Do you have or are you being treated for Cancer, HIV/AIDS?	<input type="checkbox"/>	
Do you suffer from any infectious diseases including tuberculosis?	<input type="checkbox"/>	
Are you taking warfarin or a blood thinning medication?	<input type="checkbox"/>	
Are you pregnant?	<input type="checkbox"/>	
Are there any other aspects concerning your health that you think the dentist should know about such as self prescribing medicines (for example aspirin)?	<input type="checkbox"/>	

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Date: _____

Patient Signature: _____

**Please send it back to our secure email address
theo.pelican@nhs.net**