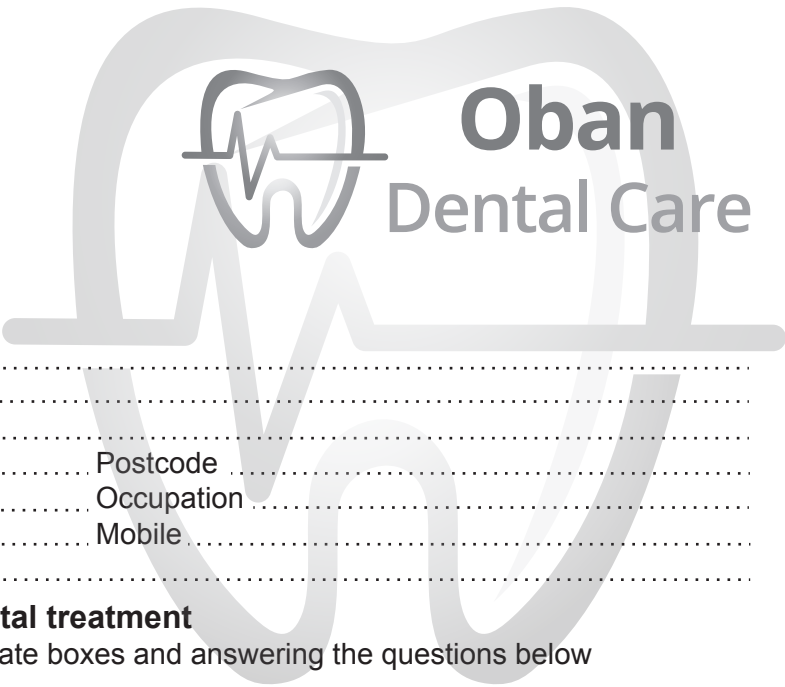


# Medical History Questionnaire



**Oban**  
Dental Care

Surname (Mr/Mrs/Miss/Ms) .....  
 Forename .....  
 Address .....  
 ..... Postcode .....  
 Date of Birth (DOB) ..... Occupation .....  
 Telephone (home) ..... Mobile .....  
 Email Address .....

**Certain medical conditions can affect dental treatment**

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

**All details will be strictly confidential**

<b>Do you have or have ever suffered from:</b>	Yes	No
Rheumatic fever? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any heart complaint, heart surgery or stroke? .....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or fainting attacks? .....	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis? .....	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding? .....	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness? .....	<input type="checkbox"/>	<input type="checkbox"/>
Do you carry a medical warning card? .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you</b> allergic to any medicine, tablets, substances or latex? (list below) .....	<input type="checkbox"/>	<input type="checkbox"/>
at present taking any medicines or tablets? (List below in notes) .....	<input type="checkbox"/>	<input type="checkbox"/>
pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
<b>In the past 2 years</b> have you undergone any operations? .....	<input type="checkbox"/>	<input type="checkbox"/>
been treated with hydro-cortisone or corticosteroids? .....	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a joint replacement operation? .....	<input type="checkbox"/>	<input type="checkbox"/>
Please tick or tell the dentist if you are HIV positive .....	<input type="checkbox"/>	<input type="checkbox"/>
What is your average weekly consumption of alcohol? .....	<input type="checkbox"/>	<input type="checkbox"/>
If you smoke, what is your average per day? .....	<input type="checkbox"/>	<input type="checkbox"/>

If 'Yes' to any questions please supply details in the 'Notes' below or use back of form

Name and address of your doctor: ..... Notes: .....

.....

.....

.....

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

Patient Signature ..... Date .....

Where did you hear about us? .....

Are you interested in  **White Fillings**  **Dental Implants**  **Cosmetic Braces**