Medical Questionnaire

TITLE:	
FIRST NAME:	
SURNAME:	
DATE OF BIRTH:	**HOME TEL:** **MOBILE TEL:**
HOME ADDRESS:	
POSTCODE:	
EMAIL:	
OCCUPATION :	
IF STUDENT SCHOOL/COLLEGE ATTENDING	
YOUR DOCTORS NAME:	
DOCTORS PRACTICE NAME:	
DOCTORS PRACTICE ADDRESS:	
POSTCODE:	

Medical History

Units of alcohol
1pint=3units, Wine 175ml = 2 unit, Alcopop 1.4 units, single spirit = 1 unit, Bottle wine = 10 units

HABITS			
	Qty		
Smoke (per day)		High sugar diet	Y/N
Chew Tobacco (per day)		Frequent fizzy drinks	Y/N
Alcohol Units (per week)		Recreational drugs	Y/N
Details			
HEART			
Rheumatic fever	Y/N	Heart Murmur	Y/N
High Blood Pressure	Y/N	Angina	Y/N
Heart surgery	Y/N	Thrombosis	Y/N
Pacemaker Fitted	Y/N	Other heart conditions	Y/N
Details			
BLOOD			
Hepatitis B	Y/N	Anaemia	Y/N
H.I.V	Y/N	Sickle cell	Y/N
Abnormal Blood Test	Y/N	Haemophilia	Y/N
Blood refused by transfusion service	Y/N	Other blood conditions	Y/N
Details			
ALLERGIES			
Penicillin	Y/N	Latex Allergy	Y/N
Hay Fever	Y/N	Medicines	Y/N
Anti Tetanus Serum	Y/N	Plants	Y/N
Eczema	Y/N	Foods	Y/N
General Anaesthetic	Y/N	Aspirin	Y/N
Local Anaesthetic	Y/N	Other Allergy Conditions	Y/N
Details			

WARNINGS			
Pregnant or possibly pregnant	Y/N	Do not Recline	Y/N
Antibiotic Cover Required	Y/N	Steroids within 2 years	Y/N
Bruising or persistent bleeding	Y/N	Warning card	Y/N
Currently under Treatment	Y/N	Treatment Req Hospitalisation	Y/N
Anything Dentist should know	Y/N		
Details			

CHEST			
Bronchitis	Y/N	Emphysema	Y/N
Cystic fibrosis	Y/N	Pneumonia	Y/N
Pleurisy	Y/N	Chest surgery	Y/N
Asthmatic	Y/N	Other chest conditions	Y/N
Details			

MEDICATION List

OTHER			
Liver Disease	Y/N	Kidney disease	Y/N
Diabetes	Y/N	Epilepsy	Y/N
Acid Reflux or eating Disorder	Y/N	Hiatus Hernia	Y/N
Bone or joint disease	Y/N	Artificial joint	Y/N
Fainting attacks or blackouts	Y/N	Giddiness	Y/N
Past serious or infectious disease	Y/N	Cancer	Y/N
Details			

Signature: ..... Date: .....

Name .....

DOB: .....