welcome

lancing dental practice

medical history questionnaire

*Please **answer all questions thoroughly**, providing as much detailed information where necessary. If you are unsure of any of the questions, please speak to your Dentist. Please **keep us updated** on any changes to your medical circumstances.*

personal details

Title: **Mr / Mrs / Miss / Ms / Other:** ..... **Date of birth:** .....

First Name: ..... **Surname:** .....

Address: .....

..... **Postcode:** .....

Telephone: **Home:** ..... **Mobile:** .....

Work: ..... **Occupation:** .....

Email: .....

medical history

	Yes	No
• Do you have, or have you suffered from **rheumatic fever**?	☐	☐
• Do you have a **heart complaint**?	☐	☐
• Have you had **heart surgery** or suffered a **stroke**?	☐	☐
• Do you have, or have suffered from **high blood pressure**?	☐	☐
• Do you have, or have suffered from **diabetes**?	☐	☐
• Do you have, or have suffered from **epilepsy** or **fainting attacks**?	☐	☐
• Do you have, or have suffered from **chronic bronchitis** or **asthma**?	☐	☐
• Do you have, or have suffered from **hepatitis**?	☐	☐
• Do you suffer from **excessive bleeding**?	☐	☐
• Do you have any **serious illness**? *please state here:*	☐	☐
• Have you ever been notified that **you are at increased risk** of **Creutzfeldt-Jakob Disease (CJD)** or **variant Creutzfeldt-Jakob Disease (vCJD)**?	☐	☐
• Do you carry a **medical warning card**?	☐	☐
• **In the past 2 years** have you been treated with **hydro-cortisone** or **corticosteriods**?	☐	☐
• Have you ever had a **joint replacement** operation?	☐	☐
• *(if applicable)* Are you an **expectant mother**?	☐	☐
• **Are you allergic** to any medicine, tablets, substances or latex?	☐	☐

If **yes**, please list here:

1. ..... 2. .....

	Yes	No
• **Are you at present taking** any **medicine** or **tablets**?	☐	☐

If **yes**, please list here:

1. ..... 5. .....
2. ..... 6. .....
3. ..... 7. .....
4. ..... 8. .....

	Yes	No
• **In the past 2 years** have you undergone any **operations**?	☐	☐

If **yes**, please list here:

.....

.....

your details will be kept private and confidential

continued overleaf

	Yes	No
• Are you **HIV positive**?	☐	☐
• What is your average weekly **consumption of alcohol** in units?	☐ units	
• If you **smoke**, how many on average do you smoke a week?	☐ per week	

consent to contact

	Yes	No
I have given Lancing Dental Practice permission to contact me on the contact details I have provided and understand that I can opt out at any time	☐	☐

your Doctor's details

Name of your Doctor: .....

Address: .....

..... **Telephone Number:** .....

in the event of an emergency please contact

Name of contact: .....

Relationship to you: ..... **Telephone Number:** .....

declaration

I hereby confirm that the information I have provided is accurate and to the best of my knowledge.

Patient / Guardian's signature ..... **Date:** .....

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updates

Please check that all the information on this form is still correct and record any changes below.

Changes advised:	**Date of Review**
	Patient's signature

Changes advised:	**Date of Review**
	Patient's signature

Changes advised:	**Date of Review**
	Patient's signature

Changes advised:	**Date of Review**
	Patient's signature

Changes advised:	**Date of Review**
	Patient's signature