Highcliffe Dental Practice

Medical Questionnaire for Dental Patients

All details will be strictly confidential

Name_____ Title____

Date of Birth_____

Address_____
_____
_____
_____Post code
_____

Telephone numbers: Home_____ Mobile _____

Email Address_____
Occupation_____

Doctors Name:_____

Surgery's Address_____
_____ Telephone
number_____

Please state any medication or treatment you are taking below?

Patient Medical Questionnaire

Are you currently receiving treatment from a doctor, hospital or clinic?	
Are you taking any prescribed medicines e.g. tablets, ointments or inhalers?	
Are you carrying a medical warning card?	
Do you suffer from allergies to any medications, substances or foods?	
Do you suffer from hay fever or eczema?	
Do you suffer from bronchitis, asthma or other chest conditions?	
Do you suffer from fainting attacks, giddiness or epilepsy?	
Do you suffer from heart problems, angina, blood pressure problems or stroke?	
Are you diabetic (or anyone in your family)?	
Do you suffer from arthritis?	
Do you suffer from bruising or persistent bleeding following injury, tooth extraction or surgery?	
Do you suffer from any infections diseases (including HIV and hepatitis)?	
Have you ever had rheumatic fever or chorea?	
Have you ever had liver disease (jaundice, hepatitis or kidney disease)?	
Have you ever had any other serious illness?	
Have you ever had blood refused by the blood transfusion services?	
Have you ever had a bad reaction to general or local anesthetic?	
Have you ever had a joint replacement or other implant?	
Have you ever had treatment that required you to be in hospital?	
Have you ever had heart surgery?	
Have you ever had brain surgery?	
Did you receive growth hormone treatment before the mid 1980's?	
Do you have any close relatives (parent, sibling, child, grandparent, or grandchild) with Creutzeldt disease?	
Do you drink more than 21 units of alcohol a week?	
Do you smoke tobacco products now or did you in the past?	
Do you chew tobacco, pan, use Gutkha or Supari or did you in the past?	
Please write down all your medication you are presently taking.	
Is there any other information which your dentist might need to know about, such as self-prescribed medicines?	

How did you hear about us?

New Milton Times ☐	Another Patient ☐	Our Web Site ☐	Google ☐	Walking Past ☐	Facebook ☐
Christchurch Eye ☐	Highcliffe Eye ☐	Village Voice (Milford on Sea) ☐	Barton Bugle ☐	Highcliffe Herald ☐	New Milton Mail
Highcliffe Golf Club Diary ☐	Christchurch Times ☐	Billboard  ☐			

Have you seen any of the promotions below, please tick where appropriate.

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Medical History

Date		

Patient Name:	

Patient D.O.B.		Age =	Over 70? (Please tick)

Are you in good health?	Yes	No
Have you had any operations or serious illnesses in the past?	Yes	No
Are you currently attending a doctor, hospital clinic or Specialist?	Yes	No
Are you or could you be pregnant/	Yes	No

Do you have, or have had any problems with the following?

Breathing e.g. asthma, COPD, bronchitis shortness of breath or a persistent cough?	Yes	No
Heart e.g. heart attack, angina, murmur, a replacement valve or pacemaker, heart failure.	Yes	No
Blood pressure?	Yes	No
Blood e.g. anaemia, prolonged bleeding, bruising, sickle cell disease, thalassemia?	Yes	No
Stomach and gut e.g. ulcers, gastric reflux or colitis?	Yes	No
Kidneys, bladder or liver e.g. chronic infections, jaundice, or cirrhosis of the liver?	Yes	No

Medical History

Nervous system e.g. epilepsy, stroke, Parkinsons or multiple sclerosis?	Yes	No
Hormones e.g. diabetes or thyroid?	Yes	No
Joints and bones e.g. arthritis or osteoporosis?	Yes	No
Skin e.g. eczema or psoriasis?	Yes	No
Mental health e.g. anxiety, depression, schizophrenia, bipolar, eating disorders?	Yes	No
Allergies or reactions to drugs, latex, food or metals?	Yes	No
Have you ever had or are having treatment for cancer e.g. chemotherapy or radiotherapy?	Yes	No
Could you have contracted an infection such as hepatitis, HIV, TB or CJD?	Yes	No
Do you have a learning disability?	Yes	No
Do you have a physical disability e.g. wheelchair use, visual or hearing?	Yes	No
Have you ever had a bad reaction to general or local anaesthetic?	Yes	No
Do you have a yearly flu jab?	Yes	No
Is your BMI over 40	Yes	No

Are you taking any Medications or drugs which are prescribed, bought over the counter?	Yes – please list below	No

Medical History

Medication	Dose

Do you smoke, vape, use shisha or chew pan?	Yes – how much?	No
Do you drink alcohol?	Yes _ how many units per week? 1 unit = ½ pint beer, small glass of wine, single measure of spirits	No

Name:	Signature:	Date: