STOKENCHURCH DENTAL CARE – MEDICAL HISTORY QUESTIONNAIRE

Please complete all relevant sections in **BLOCK CAPITALS**.

It is important for your dentist to have your medical history and understand your health needs before any examination or treatment is carried out. If you are a new patient to the centre, please complete the following form for your first assessment. Medical information will be kept strictly confidential.

Title: *(Mr, Mrs, Miss, Ms, other title)*

Surname:

First name(s):

Date of birth:

Address:

Postcode:

Daytime telephone no:	Evening telephone no:
Mobile telephone no:	Email address:
Occupation:	Company name:

How did you hear about us?

Signature:

Are you insured for any dental care? Yes ○ No ○ (optional)

If yes, under which insurer or plan?

Medical History Questionnaire - Confidential

Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions.

GP name:

Telephone no:

Address

Have you been seen by your GP during the past year?	Yes	No
Are you presently under medical care or taking any medication (tablets, medicines or drugs)? If yes, please list:	Yes	No
Are you taking or have you taken steroids in the last two years?	Yes	No
Have you ever had a prolonged illness or been hospitalised?	Yes	No
Have you had any major/serious operations or radiation therapy?	Yes	No

Do you have or have you had any of the following?

Rheumatic fever/ chorea	Yes	No	High blood pressure	Yes	No	Diabetes – low blood sugar	Yes	No
Congenital heart lesion/cardiac pacemaker	Yes	No	Low blood pressure	Yes	No	Hiatus hernia/ stomach trouble	Yes	No
Heart attack/ angina	Yes	No	Jaundice, hepatitis, liver disease	Yes	No	Asthma or hay fever	Yes	No
Heart murmur	Yes	No	HIV/AIDS	Yes	No	Epilepsy	Yes	No

Do you have or have you had any contact with Hepatitis or HIV/AIDS carriers which is likely to put you at risk from either of these viruses?	Yes	No
Did you as a child or since have brain surgery, growth hormone treatment before the mid-1980's or have a close relative with CJD?	Yes	No
Have you ever had any ill effects following dental treatment?	Yes	No
Have you or any relation had any severe prolonged bleeding problems?	Yes	No
Are you allergic to, or made ill by any medications?	Yes	No
Have you had any ill effects from	Yes	No

penicillin?

Have you had any ill effects from any other antibiotic?	Yes	No
Have you had any ill effects from local anaesthetic?	Yes	No
Have you ever had any ill effects from aspirin?	Yes	No
Do you smoke?	Yes	No

Applicable to women only		
Are you pregnant or is it possible you may be pregnant?	Yes	No
Are you taking contraceptive pill? Certain medication may compromise its effectiveness.	Yes	No
Is there any other information about your medical history which may be important? If so, please list below.	Yes	No

What prompted you to seek dental care at this time?

How long is it since your last thorough dental examination with X-rays?

What words best describe your past dental experiences?

Caring	Relaxed	Modern	Painful
Stressful	Sympathetic	Rushed	Good value
Uncomfortable	High-Tech	Old fashioned	No choice

Has the fear of discomfort kept you from regular visits?	Yes	No
Have you experienced any discomfort in your teeth recently?	Yes	No
Are you aware of any grinding or clenching of your teeth?	Yes	No
Do your jaw joints ever hurt or click?	Yes	No
Do you suffer from headaches, migraine pains in your	Yes	No

face or your ear?

Do your gums bleed easily, feel tender or irritated?	Yes	No
Are you troubled with bad breath or a bad taste?	Yes	No

Would you like to know more about?

Teeth whitening	Yes	No	Teeth straightening	Yes	No
Replacing missing teeth	Yes	No			

Signature:	Date: