ENDODONTIC PRACTICE CONFIDENTIAL MEDICAL HISTORY

Mr / Mrs / Miss / Ms

Name:

Address:

Post Code:

Telephone Number(s) (H) (M)

Email address:

Doctors Name:

Address:

Telephone Number:

Your Date of Birth: / /

The contents of this questionnaire are confidential and will provide us with essential information to allow us to meet your needs and to safeguard your health.

ARE YOU

1) Attending or receiving treatment from a doctor, hospital, clinic or specialist? YES / NO
2) Taking or using any medicine, pills, tablets or any other drug? IF SO,WHAT: YES / NO
3) Allergic to any medicines (e.g penicillin), foods or materials? YES / NO
4) Pregnant or planning to become pregnant? YES / NO

HAVE YOU

1) Had rheumatic fever or chorea (St. Vitus' Dance)? YES / NO
2) Had hepatitis, jaundice, liver disease or kidney disease? YES / NO
3) Ever been told you have a heart murmur or heart problem? YES / NO
4) Suffered from angina, high blood pressure or a heart attack? YES / NO
5) Ever had your blood refused by the Blood Transfusion Service? YES / NO
6) Had a joint replacement? YES / NO
7) Taken steroids in the last two years? YES / NO
8) Been hospitalised? YES / NO
9) Been diagnosed, or had reason to believe, that you might be HIV Positive? YES / NO
10) Had Growth/Pituitary Hormone Treatment since 1984? YES / NO
11) Had brain surgery including dura mater grafts? YES / NO
12) A close relative with Creutzfeldt Jakob Disease? YES / NO

DO YOU

1) Bruise easily or, following a tooth extraction, surgery or injury have you or anyone in your family, bled so as to cause worry or seek medical attention? YES / NO
2) Have a pacemaker, or have you had any form of heart surgery? YES / NO
3) Suffer from bronchitis, asthma or chest conditions? YES / NO
4) Have fainting attacks, giddiness, blackouts or epilepsy? YES / NO
5) Have diabetes or does anyone in your family? YES / NO
6) Have arthritis? YES / NO
7) Carry a steroid warning card? YES / NO
8) Smoke cigarettes/cigars/pipe or chew tobacco? Quantity_____ per day YES / NO
9) Drink alcohol? Number of units_____ per week (1 Glass of wine is 1.5 units) YES / NO
10) Have any objections to us holding computerised information about your treatment? YES / NO

Are there any other aspects of your health that you feel your dentist should know?

Details of any Yes replies will be discussed with the Dentist.

I consent to the treatment set out in the information sent to me through the post or email.

Please check the details above and if you are happy they are correct please sign and date in the space below

…… ……..

Signed PATIENT **Date PATIENT**