ROYSTON
DENTAL PRACTICE

**Confidential Medical Questionnaire**

| Name | | DOB | | Family Doctor |
|---|---|---|---|---|
| Address | | | | |
| Tel. Home | | Mobile | | |
| email | | | | |
| Referring Dentist | | | | |

| | Yes | No |
|---|---|---|
| Are you under the care of a doctor | | |
| Have you recently been ill | | |
| Have you ever had a serious illness | | |
| Have you ever been in hospital | | |
| | | |
| Have you ever suffered from: | | |
| Heart problems | | |
| Angina | | |
| High Blood Pressure | | |
| Heart Murmur | | |
| Breathing Problems | | |
| Shortness of Breath | | |
| Asthma | | |
| Eczema | | |
| Aneamia | | |
| Rheumatic Fever | | |
| Diabetes | | |
| Epilepsy | | |
| Jaundice | | |
| Hepatitis | | |
| Excess Bleeding | | |
| Excess Bruising | | |
| Sinusitis | | |
| Headaches | | |
| | | |
| Do you have any Allergies | | |
| Are you allergic to any of the following: | | |
| Penicillin | | |
| Aspirin | | |
| Local Anesthetic | | |
| Latex | | |
| Iodine | | |
| Food | | |
| Animals | | |
| Pollen | | |

| | Yes | No |
|---|---|---|
| Are you taking any medication, including tablets, inhalers, injections, creams, oral contraceptive, HRT or antidepressents. | | |
| | | |
| Do you have osteoporosis | | |
| Have you had treatment for osteporosis | | |
| | | |
| Have you ever been prescribed steroids | | |
| Have you ever had treatment for anxiety or depression | | |
| Have you had treatment for a psychiatric disorder or addiction | | |
| Have you had treatment for a tumour | | |
| | | |
| Smoking | | |
| Do you smoke cigarettes/ pipe/ roll ups | | |
| How many per day | | |
| Would you like help to stop smoking | | |
| | | |
| If you used to smoke | | |
| When did you stop | | |
| How much did you smoke per day | | |
| | | |
| How many units of alcohol do you drink per week | | |

Details of Medical Conditions and Medication

Patients Signature ______________________ Date ______________