WHYMAN HOUSE DENTAL PRACTICE

MEDICAL HISTORY QUESTIONNAIRE

Please answer all the questions below. If the answer is Yes to any question please give as much additional information as you can.

NAME	DATE OF BIRTH	ADDRESS and CONTACT NUMBER

DESCRIPTION	YES	NO	COMMENTS
Do you have a history of problems with Dental Treatment? e.g. fainting with extractions, bleeding etc			
History of Heart Problems?			
History of Angina?			
History of rheumatic fever?			
History of blood pressure problems?			
History of thyroid problems?			
History of jaundice or diabetes?			
History of epilepsy, blackouts, having fits?			
History of chest problems?			
History of asthma or bronchitis?			
History of serious illness or operations?			
Have you ever had a general anaesthetic?			
Under medical care in the last 12 months?			
Do you have any allergies?			
Are you taking any medicine, tablets or natural remedies? If yes give details of drug and daily dosage.			

SMOKING AND ALCOHOL INFORMATION	YES	NO	DETAILS
Are you a smoker? If so please give details?			
Are you an ex smoker? If so when did you completely give up?			
Do you drink alcohol? If yes, how many units per week?			

FEMALES ONLY	YES	NO	COMMENTS
Are you pregnant or is there a possibility that you could be pregnant?			
Are you taking the oral contraceptive pill?			

NAME OF DOCTOR (GP)	ADDRESS OF GP

PRINT NAME	SIGNATURE	DATE