Fern Cottage Dental Practice
01226 742304
fcdental.co.uk

Date	Signed		Date	Signed	

MEDICAL HISTORY QUESTIONNAIRE

Name:	Address:
DOB:	
Home Tel:	
Mobile:	
Email:	

Please tick yes or no for all answer. Cross out where applicable.

	NO	YS
Are you currently receiving treatment from a doctor, hospital or clinic?		
Are you taking any regular/prescribed medication? Please list at bottom		
Are you pregnant or possibly pregnant ?		
Are you currently carrying a medical warning card?		
Do you have allergies to any medicines (e.g. antibiotics), substances (e.g. latex/rubber) or foods? **Please list**: Allergies:_____		
Do you have diabetes?		
Do you suffer from hay fever or eczema?		
Do you suffer from fainting attacks, giddiness, blackouts or epilepsy?		
Do you have bronchitis, asthma or other chest condition?		
Do you suffer form arthritis?		
Do you get bruising or persistent bleeding following injury, tooth extraction or surgery?		
Do you smoke? If so, **how many** a week?		
Have you ever had any infectious diseases including HIV or hepatitis?		
Have you ever had heart surgery?		
Have you ever had heart problems, angina, blood pressure problems, stroke or pacemaker?		
Have you ever had a bad reaction to general or local anaesthetic?		
Have you ever had rheumatic fever or chorea (St Vitus Dance)?		
Have you ever suffered form liver disease (E.g. jaundice, hepatitis) or kidney disease?		
Have you ever had any other serious illness or infectious disease?		
Have you ever had blood refused by the Blood Transfusion Service?		
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 brain surgery?		
Units of alcohol consumed a week:		

List any medications: