Sundon Dental Practice

Tel: 01582 571074

115 Sundon Park Road Luton, Beds LU3 3AD

E-mail: sundon.reception@hotmail.com

**CONFIDENTIAL MEDICAL QUESTIONNAIRE**

All answers provided will remain strictly confidential.

Please complete as fully as possible.

First Names

Title

Surname

Date of Birth

Occupation

Home Tel

Email Address

Work/Mob Tel

Doctors Tel

*Please Turn Over*

**Questions**

Are you currently:

1. Likely to be pregnant?

**Yes**

**No**

**Relevant Details/Name of Medication**

2. Receiving any medical treatment?

3. Taking any medication inc. tablets,

creams, injections, inhalers and oral contraceptives?

4. Allergic to any medicines (e.g. penicillin) or substances (e.g. latex/rubber)?

**Medical History:**

**Have you ever had (past or present):**

1. Heart problems, angina, heart attack or stroke?

2. High or low blood pressure?

3. Rheumatic fever?

4. Heart valve replacement?

5. Hepatitis, jaundice or other liver problems?

6. Kidney problems?

7. Chest problems e.g.

asthma, emphysema, bronchitis?

8. Blood related diseases or been refused by the blood transfusion service?

Doctors Name and Address

Work Address

Postcode

Home Address

Postcode

**Other relevant information:**

How did you find out about the Practice?

When was the last time you visited a Dentist?

Please give details of any current dental problems you are aware of.

Are you happy with your teeth, if not, what would you like to change (e.g. tooth discolouration, missing teeth, bad breath)?

**Yes**

**No**

Are you exempt from NHS charges?

If so please indicate type (e.g. income support):-

**Yes**

**No**

Do you have any Private Medical/Dental Insurance?

**PLEASE SIGN BELOW**

Thank you for completing the questionnaire. This will allow our team to have a full understanding of your medical history and expectations and provide you with the best care possible.

**PATIENT SIGNATURE**

**DATE CHECKED**

**DENTIST SIGNATURE**

**Questions**

**Yes**

**No**

**Relevant Details/Name of Medication**

9. Bad reaction to local or general anaesthetic?

10. A joint replacement or other implant?

11. Growth hormone treatment before the mid 80’s?

**Do you:**

1. Carry any warning cards?

2. Have arthritis?

3. Have a pacemaker?

4. Have epilepsy, fainting attacks or giddiness?

5. Have diabetes or does anyone in your family?

6. Bruise easily or ever bled excessively?

7. Take or have taken steroids in the past?

8. Suffer from HIV/AIDS or any other infectious diseases?

9. Suffer from any other serious illnesses?

10. Have a relative with Creutzfeldt Jakob Disease (CJD)?

11. Smoke, if yes, how many per day & for how long?

12. Drink alcohol, if yes, how much per week?

e.g glasses of wine/pint of beer etc

(Pint of beer = 2 units, Glass of wine = 2 units, Spirit = 1 unit)