Sundon Dental Practice

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115 Sundon Park Road
Luton, Beds LU3 3AD

CONFIDENTIAL MEDICAL QUESTIONNAIRE

All answers provided will remain strictly confidential. Please complete as fully as possible.

Title | Surname | First Names

Date of Birth | Weight | Occupation

Home Address

Postcode

Work Address

Postcode

Home Tel | Work/Mob Tel

Email Address

Doctors Name and Address

Doctors Tel

NHS Number

Do you require a downstairs surgery? Yes / No

Questions: Are you currently: 1. Pregnant or likely to be pregnant?	**Yes**	**No**	**Relevant Details/Name of Medication**
2. Receiving any medical treatment from a doctor, hospital or clinic?			
3. Taking any prescribed medication e.g. tablets, creams, ointments, injections, inhalers, oral contraceptives or hormone replacement therapy? If answered **Yes**, please provide an up-to-date list of any prescribed medications, e.g a copy of a repeat prescription.			
4. Allergic to any medicines (e.g Penicillin) or substances (e.g latex/rubber) or foods?			
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 or chorea?			
4. Heart surgery or heart valve replacement?			
5. Hepatitis, jaundice or other liver problems?			
6. Kidney problems?			
7. Chest problems e.g asthma, emphysema, bronchitis or other chest conditions?			
8. Blood related diseases or have you ever had refused by the Blood Transfusion service?			
9. A bad reaction to local or general anaesthetic?			

Questions 10. A joint replacement or other implant?	Yes	No	Relevant Details/Name of Medication
11. Growth hormone treatment before the mid 1980's?			
12. Brain surgery?			
13. Treatment that required you to be in hospital?			
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. Chew any tobacco products now (or in the past)?			
13. 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)			

Is there any other information which your dentist might need to know about, such as self-prescribed medicines (e.g aspirin)?			

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)?

Are you exempt from NHS charges? **Yes** **No**

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

Do you have any Private Medical/Dental Insurance? **Yes** **No**

PLEASE SIGN BELOW

PATIENT SIGNATURE	DATE CHECKED	DENTIST SIGNATURE

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.