DENCHIC
DENTAL SPA

MEDICAL HISTORY QUESTIONNAIRE

Surname (Mr/Mrs/Miss/Ms)……
Forename……..
Address……
…… Postcode……..
Tel No. Home ……Mobile……..
Date of Birth ……Occupation……
E-Mail ……..
How did you hear about us ……..

Certain medical conditions can affect dental treatment and vice versa.
All details will be strictly confidential.

Do you have or have you ever suffered from:
Rheumatic fever?.....Y/N
Any heart complaint, heart surgery or stroke?.....Y/N
Diabetes?.....Y/N
Epilepsy or fainting attacks?.....Y/N
Chronic bronchitis or asthma?.....Y/N
Hepatitis?……...Y/N
Excessive bleeding?..... Y/N
High blood pressure?..... Y/N
Any other serious illness?..... Y/N
Do you carry a medical warning card?..... Y/N
Are you allergic to any medicine or tablets?..... Y/N
Are you pregnant?..... Y/N
In the past 2 years have you undergone any operations?..... Y/N
In the past 2 years have you been treated with hydro-cortisone?..... Y/N
Have you ever had a joint replacement operation?..... Y/N
Are you HIV positive?..... Y/N
What is your average weekly consumption of alcohol?.....
If you smoke, what is your average per week?.....
Can we send you a text or leave a voice message on your answer machine if we can't get in touch with you over the phone?..... Y/N

If 'yes' to any questions please supply details in 'Notes' below.

Name and address of your GP: **Notes:**
…… ……
…… ……..

If you are not sure about any of the questions, or if your medical circumstances have changed, please inform the dental surgeon.
If you are not able to keep your appointment, please contact us 24 hours prior to your appointment.

Patient's Signature **Date**

…….. ……