

CONFIDENTIAL MEDICAL & GENERAL QUESTIONNAIRE

In order to help our Dental Team provide the best and safest care, please take a few minutes to fill in this questionnaire.

NAME: _____ **DATE OF BIRTH:** / /

ADDRESS: _____

OCCUPATION: _____
(If retired previous)

DOCTORS NAME: _____ **GP Phone No:** _____

MEDICAL

- 1. Do you suffer from a heart complaint? Or had heart surgery **YES/NO**
(such as Angina/Heart-attack/Murmurs/High Blood Pressure/Pacemaker)
- 2. Do you suffer from a chest complaint? **YES/NO**
(such as Asthma/Bronchitis/TB/Breathlessness)
- 3. Are you a smoker, or have you smoked in the past? **YES/NO**
- 4. Do you suffer from any Blood disorders? **YES/NO**

(such as Haemophilia/Sickle cell/Easy bruising/Prolonged Bleeding)

- 5. Do you suffer from Diabetes? **YES/NO**
- 6. If yes, is your Diabetes treated with **DIET/TABLETS/INSULIN**
- 7. Do you take any medication? **YES/NO**
(such as Warfarin/Steroids/Antidepressants/Blood Pressure Tablets)

PLEASE CAREFULLY LIST ALL ON THE OTHER SIDE OF THIS PAGE.

- 8. Are you allergic to any medications? **YES/NO**
(Especially any antibiotics)
- 9. Do you suffer from Fit/Faints/Epileptic attacks? **YES/NO**
- 10. Have you had Jaundice/Liver disease/Hepatitis? **YES/NO**
- 11. Have you ever had a General Anaesthetic? **YES/NO**
- 12. Are you pregnant? **YES/NO**
- 13. Have you had any previous bad dental experiences? **YES/NO**
- 14. Have you had a bad reaction to a dental anaesthetic? **YES/NO**
- 15. Is there anything else you feel your dentist should know? **YES/NO**

PLEASE LIST ANY OTHER DETAILS ON THE OTHER SIDE OF THIS PAGE.

GENERAL (Optional)

- 1. Are you happy with the state of your teeth and smile? **YES/NO**
- 2. Apart from assessing your Basic Dental Fitness would you like to know of other options to improve your Teeth/Smile? **YES/NO**

Patient Signature : _____ Date: _____