

## REGISTRATION/MEDICAL HISTORY QUESTIONNAIRE

Mr/Mrs/Miss/Ms Surname.....	Email.....
Forename(s).....	
Address.....	
Post Code.....	Tel (Home)..... Tel (Work).....
Date of Birth.....	Occupation.....

**Certain medical conditions can affect dental treatment and vice versa**

*Please complete this form as accurately as possible. All details will be kept strictly confidential.*

<b>Do you have or have you ever suffered from:</b>	<b>Yes</b>	<b>No</b>
rheumatic fever?.....	<input type="checkbox"/>	<input type="checkbox"/>
any heart complaint (including heart murmur)?.....	<input type="checkbox"/>	<input type="checkbox"/>
diabetes?.....	<input type="checkbox"/>	<input type="checkbox"/>
epilepsy?.....	<input type="checkbox"/>	<input type="checkbox"/>
chronic bronchitis or asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>
hepatitis?.....	<input type="checkbox"/>	<input type="checkbox"/>
excessive bleeding?.....	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure?.....	<input type="checkbox"/>	<input type="checkbox"/>
any other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you</b>		
been infected with CJD or HIV.....	<input type="checkbox"/>	<input type="checkbox"/>
been treated with hydro-cortisone or corticosteroids.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you</b>		
smoke/use any form of tobacco ( <i>Please state daily quantity</i> ) .....	<input type="checkbox"/>	<input type="checkbox"/>
drink alcohol ( <i>Please state weekly units</i> ).....	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you</b>		
pregnant .....	<input type="checkbox"/>	<input type="checkbox"/>
allergic any drugs or to latex, foods or material?.....	<input type="checkbox"/>	<input type="checkbox"/>
are you at present taking any medications or tablets? ( <i>Please state below</i> )	<input type="checkbox"/>	<input type="checkbox"/>

MEDICATION / DRUGS (inc. dose and freq)	Date Started	Date stopped

<b>Notes</b> ..... ..... ..... ..... .....	<b><u>GP DETAILS</u></b> ..... ..... ..... ..... .....
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Patient Signature..... Date.....