REGISTRATION/MEDICAL HISTORY QUESTIONNAIRE

(All information recorded is held confidentially, in line with the Data Protection Act of 1998)

Mr/Mrs/Miss/Ms

Surname.....

Forename(s).....

Address..... **Post Code**.....

Tel (home)..... **Mobile**.....

Date of Birth..... **Occupation**.....

Email..... **Would you like to receive SMS reminders of future appointments?** YES/NO

Certain medical conditions can affect treatment and vice versa. Please complete this form as accurately as possible

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

MEDICATION/DRUGS (include dose and frequency)	**Date started**	**Date stopped**

GP details:

Please tick the box if you might be interested in the following treatments:

Teeth whitening	☐	Help with snoring/grinding teeth	☐
Teeth straightening	☐	Facial rejuvenation	☐

Are you a new patient? Where did you hear about our practice?

NHS website / Internet search / Word of mouth / Leaflet / Other:.....

Patient signature..... **Date**.....