|  |  |
| --- | --- |
| Surname: | First name: |
| Date of Birth: | Sex M/F:  MR, MRS, MS, MISS, MST: |
| Address:  Occupation: | Telephone:  Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How Did you hear about us? (New patients only) |
| GP contact details: | Emergency contact details: |

Medical History Questionnaire( Please fill in all 3 pages)

**Yes/No**

|  |  |
| --- | --- |
| Are you currently **receiving treatment from a doctor, hospital or clinic?** If ‘YES’ please give details |  |
| Are you currently taking any **prescribed medicines** (eg tablets, ointments or inhalers, including contraceptives and hormone replacement therapy)? Please list |  |
| Are you carrying a **medical warning card?**  If ‘YES’, why? |  |
| Are you currently **pregnant**?  If ‘YES’ which trimester and what is your due date? |  |
| Do you suffer from **bronchitis**, **asthma** or other **chest conditions**?  If ‘YES’ please give details |  |
| Do you have any **allergies** ? If ‘YES’ please give details |  |
| Do you suffer from **fainting attacks**, **giddiness**, **blackouts** or **epilepsy**?  If ‘YES’ please give details |  |
| Do you suffer from **heart problems, angina, blood pressure problems or stroke**? If ‘YES’ please give details |  |
| Are you **diabetic**? (Or is anyone in your family?) If ‘YES’ give details |  |
| Do you suffer from **arthritis**? Which type? |  |
| Do you suffer from **bruising** or **persistent bleeding** following injury, tooth extraction or surgery? If ‘YES’ please give us more information |  |
| Have you ever had **liver disease** (eg jaundice, hepatitis) or **kidney disease?** If ‘YES’ please give details |  |
| Do you suffer from any **infectious diseases** (including HIV & hepatitis)?  If ‘YES’ please give details |  |
| Have you ever had blood **refused** by the Blood Transfusion Service?  If so, why? |  |
| Have you ever had a **bad reaction** to general or local **anaesthetic**? If so please give us more information |  |
| Have you ever **had treatment that required you to be in hospital**? If ‘YES’ please give details and dates |  |
| Have you ever had **heart surgery**? If ‘YES’ please give us more information |  |
| Have you ever had **rheumatic fever** or chorea? If ‘YES’ please give details |  |
| Have you ever had any **other serious illness**? If ‘YES’ please give us more information |  |
| Do you have any close relatives (parent, sibling, child, grandparent or  Grandchild) with **Creuzfeldt Jakob Disease**? If ‘YES’ please give details |  |
| Do you drink **alcohol**? If ‘YES’ how many units per **week**?  (1 unit = a single measure of spirits ABV 37.5% **OR** a half pint of average strength lager **OR** half a 175ml glass of average strength wine) |  |
| Do you **smoke any tobacco products** now (**or have you in the past**)?  If **‘Yes’**, how many?  If you used to smoke when did you stop? |  |
| Do you **chew tobacco**, **paan**, use **gutka** or **supari** now(**or in the past**)?  Please give details of quantity etc  If in the past when did you stop? |  |
| Is there anything else you would like your Dentist to know? |  |

Patient signature:……………………………………………………………………..Date:……………………….

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**IF EMAILING THIS FORM BACK TO US AFTER COMPLETION PLEASE SEND IN .pdf format or .doc format. Thank you.**