Longborough Dental Practice - Medical History Questionnaire

Please complete all of the following (write as clearly as possible) All details will be strictly confidential.
We collect and use this information to allow us to fulfil our contract with you to provide dental care that meets your needs. This form will be digitally stored and securely disposed of.

Title: _____Forename: _____Surname: _____
Date of birth: _____
Address:_____
_____Post code: _____
Email address: _____
Tel (mobile): _____Tel (home): _____
Occupation: _____
Name of your emergency contact: _____
Emergency contact no. _____ Relationship to you: _____
Name of your doctor's practice: _____

Certain medical conditions can affect/be affected by dental treatment. If you are unsure about any of the questions or if your medical circumstances change, please inform your dentist.

Do you have or have you ever suffered from:	**YES**	**NO**
Rheumatic fever?		
Any heart complaint, heart surgery or stroke?		
Diabetes?		
Epilepsy or fainting attacks?		
Chronic bronchitis or asthma?		
Hepatitis?		
Bleeding or clotting disorders?		
High blood pressure?		
	YES	**NO**
In the past 5 years have you undergone any operations?		
In the past 5 years have you been treated with corticosteroid tablets?		
Are you pregnant?		
Please tick or tell the dentist if you are HIV positive		
	YES	**NO**
Are you allergic to any medicine, tablet or substance? Such as latex		
Are you taking any medicines or tablets?		
Do you carry a medical warning card?		
Any other medical conditions?		

If yes to any of the above please supply details here or overleaf (including any medications and dosages)

What is your average weekly consumption of alcohol?	
If you smoke, what is your average per day?	

Patient's signature: _____Date:_____