

# Medical History Questionnaire



St Mary's Dental Practice  
34A St Mary's Street,  
Stamford, Lincs,  
PE9 2DS  
Tel: 01780 755005  
reception@stmarysdentastamford.co.uk

## Your personal details

Title: (Mr, Mrs, Ms, other title)	
First Names: (s) (please include all forenames in full)	
Surname:	
Address:	
Post Code:	
Date of Birth:	D D M M Y Y Y Y
Home telephone number:	
Work Telephone number:	
Mobile telephone number:	
Email address:	
How did you hear about us?	

## Details of contact in case of emergency

Name:	
Telephone number:	

## Next of Kin

Name:	
Telephone number:	

## Insurance details

Are you insured for any dental care?	<input type="checkbox"/> Yes <input type="checkbox"/> No (optional)
If yes, under which insurer or plan?	
Membership number (if applicable):	

## Medical history questionnaire – *confidential*

Please fill in this section carefully. It is important that your dentist has your full medical history. Please ask your dentist's advice if you are unsure about any of the questions.

GP name:			
Telephone number:			
Address:			
Post Code:			
Have you been seen by your GP during the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you presently under medical care or taking any medication (tablets, medicines or drugs)? If Yes, please list:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you taking or have you taken steroids in the last two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had a prolonged illness or been hospitalised?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had any major / serious operations or radiation therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### ***Do you have or have you had any of the following?***

Rheumatic fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Congenital heart lesion / cardiac pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Low blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma or hay fever	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes – low blood pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hiatus hernia / stomach trouble	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Jaundice, hepatitis, liver disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bone or joint disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	HIV / AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you have or have had any contact with Hepatitis or HIV / AIDS carriers which is likely to put you at risk from either of these viruses.			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Did you as a child or since have brain surgery, growth hormone treatment before the mid-1980s or have a close relative with CJD?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you or any relation had any severe prolonged bleeding problems?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you any allergies to medicines i.e. penicillin, substances or materials (latex/rubber)?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you had any ill effects from any other antibiotics?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you smoke any tobacco, pan/betel nut or similar products? If yes, how many a day? ..... cigarettes			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Have you previously smoked?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Do you drink alcohol? If yes, approximately how many units per week ..... units			Yes <input type="checkbox"/>	No <input type="checkbox"/>	

**The next two questions are applicable to women only.**

Are you pregnant or is it possible you may be pregnant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you taking contraceptive pill? Certain medication may compromise its effectiveness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is there any other information about your medical history which may be important?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Dental History**

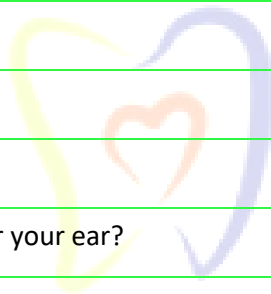
What prompted you to seek dental care at this time?

How long is it since your last thorough dental examination with X-rays?

What words best describe your past dental experiences?

- Caring     Relaxed     Modern     Painful     Stressful     Sympathetic  
 Rushed     Good value     High-tech     Old Choice     No choice     Uncomfortable

Has the fear of discomfort kept you from regular visits?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you experienced any discomfort in your teeth recently?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you aware of any grinding or clenching of your teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do your jaw joints ever hurt or click?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you suffer from headaches or migraine pains in your face or your ear?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do your gums bleed easily, feel tender or irritated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are you troubled with bad breath or a bad taste?	Yes <input type="checkbox"/>	No <input type="checkbox"/>



**Would you like to know more about any of the following?**

Teeth whitening	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Teeth straightening	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Replace missing teeth?	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

**I give my consent to my contact details being used for the following**

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I understand a minimum of 24 hours' notice must be given to change or cancel an appointment. A cancellation fee of 50 percent of your treatment cost will apply if changes are made less than 24 hours' notice.

Patient signature (or parent / guardian signature if under 16)

Date: 

D	D	M	M	Y	Y	Y	Y
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Dentist / Dental Professional signature:

Date: 

D	D	M	M	Y	Y	Y	Y
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