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?	☐ Yes ☐ 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?	☐ Yes	☐ No
Are you presently under medical care or taking any medication (tablets, medicines or drugs? If Yes, please list:	☐ Yes	☐ No
Are you taking or have you taken steroids in the last two years?	☐ Yes	☐ No
Have you ever had a prolonged illness or been hospitalised?	☐ Yes	☐ No
Have you had any major / serious operations or radiation therapy?	☐ Yes	☐ No

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

Rheumatic fever	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Congenital heart lesion / cardiac pacemaker	Yes ☐	No ☐	Low blood pressure	Yes ☐	No ☐
Asthma or hay fever	Yes ☐	No ☐	Diabetes – low blood pressure	Yes ☐	No ☐
Hiatus hernia / stomach trouble	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Jaundice, hepatitis, liver disease	Yes ☐	No ☐
Bone or joint disease	Yes ☐	No ☐	HIV / AIDS	Yes ☐	No ☐

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 ☐	No ☐
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 ☐	No ☐
Have you or any relation had any severe prolonged bleeding problems?	Yes ☐	No ☐
Have you any allergies to medicines i.e. penicillin, substances or materials (latex/rubber)?	Yes ☐	No ☐
Have you had any ill effects from any other antibiotics?	Yes ☐	No ☐
Do you smoke any tobacco, pan/betel nut or similar products? If yes, how many a day? …….. cigarettes	Yes ☐	No ☐
Have you previously smoked?	Yes ☐	No ☐
Do you drink alcohol? If yes, approximately how many units per week …….. units	Yes ☐	No ☐

The next two questions are applicable to women only.		
Are you pregnant or is it possible you may be pregnant?	Yes ☐	No ☐
Are you taking contraceptive pill? Certain medication may compromise its effectiveness?	Yes ☐	No ☐
Is there any other information about your medical history which may be important?	Yes ☐	No ☐

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 ☐	No ☐
Have you experienced any discomfort in your teeth recently?	Yes ☐	No ☐
Are you aware of any grinding or clenching of your teeth?	Yes ☐	No ☐
Do your jaw joints ever hurt or click?	Yes ☐	No ☐
Do you suffer from headaches or migraine paints in your face or your ear?	Yes ☐	No ☐
Do your gums bleed easily, feel tender or irritated?	Yes ☐	No ☐
Are you troubled with bad breath or a bad taste?	Yes ☐	No ☐

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

Teeth whitening	Yes ☐	No ☐	Teeth straightening	Yes ☐	No ☐
Replace missing teeth?	Yes ☐	No ☐			

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

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	

Dentist / Dental Professional signature:

Date:	D	D	M	M	Y	Y	Y	Y	