YOURDENTIST
Your first choice for dental care in Bristol City Centre

New Patient Confidential Medical Questionnaire

Please write clearly **All your details will be kept strictly confidential**

Miss / Mrs / Ms / Mr / No title Surname (last name):

First Name: Sex: F / M Date of birth:

House/Flat No: Street:

Post Code: City: NHS No:

Telephone/Mobile No: /

We correspond primarily electronically **Can we contact you by email?** Yes ☐ No ☐

Email address: @

Your GP's Name and address:

Occupation: When was your last dental visit?

How did you hear about our practice?

To provide the safest treatment Your Dentist needs to know of any medical problems which may affect your treatment. We are required to obtain an updated Medical questionnaire for all new courses of treatment.

Are you:			**If YES please give supporting details**
- Currently under care of a Doctor or hospital for **ANY** treatment?	Yes ☐	No ☐	
- Taking **ANY** medicines prescribed or over –the-counter? (Incl. Use of steroids over the past 2 years) Please list Medication or provide separate prescription list for our file.	Yes ☐	No ☐	Please continue overleaf
- Allergic to Penicillin, Latex, Chlorhexadine ('Corsodyl') or any other medication or Materials?	Yes ☐	No ☐	
Do you have or have you ever had:			
- Heart disease (eg: Angina, heart attack, heart murmurs, Valve problems, heart surgery?	Yes ☐	No ☐	
- Pacemaker fitted?	Yes ☐	No ☐	
- High Blood Pressure / Stroke?	Yes ☐	No ☐	
- Rheumatic Fever or Endocarditits?	Yes ☐	No ☐	
- Bleeding disorders? (eg: anaemia, anticoagulant treatment)	Yes ☐	No ☐	
- Asthma, Bronchitis, TB / other chest disease?	Yes ☐	No ☐	
- Liver or Kidney disease?	Yes ☐	No ☐	
- Infectious diseases (eg: Hepatitis, HIV)?	Yes ☐	No ☐	
- Epilepsy, Convulsions, Neurological disease?	Yes ☐	No ☐	
- Mental illness / Learning difficulties?	Yes ☐	No ☐	
- Chemotherapy / Radiotherapy	Yes ☐	No ☐	Dates:
- Skin disease, Eczema, Dermatitis?	Yes ☐	No ☐	
- Diabetes, Thyroid / other hormonal disorder?	Yes ☐	No ☐	
- Bone or joint disease (e.g. Arthritis, osteoporosis)? Bisphosphonate medication?	Yes ☐	No ☐	
- Bad reaction to anaesthetics?	Yes ☐	No ☐	
- Any other health issues?	Yes ☐	No ☐	
If Female - could you be pregnant?	Yes ☐	No ☐	If yes - Due date?
Are you a nursing mother?	Yes ☐	No ☐	

How much of the following do you consume per day? Cigaretts: Alcoholic drinks:

Patient / Guardian signature: Date: