YOURDENTIST
Your first choice for dental care in Bristol City Centre

Patient Confidential Medical Questionnaire

Please write clearly and in capital letters **All your details will be kept strictly confidential**

Miss / Mrs / Ms / Mr / No title First name: Middle name:

Last name: Gender: F / M Date Of Birth:

House/Flat No: Street:

Area: Post Code: City:

We send SMS and email reminders, please provide us with appropriate contact details

Telephone: E-mail

Name of your GP Surgery: Your NHS No:

Your Occupation: Last dental visit?

How did you hear about our practice?

To provide the safest treatment Your Dentist needs to know of any medical issues which may affect your treatment

Do you have or have you ever had:	**No**	**Yes**	**Details:**
Heart disease (eg: Angina, Heart attack, Heart murmurs, Valve problems, Heart surgery	☐	☐	
Pacemaker fitted	☐	☐	
Stroke	☐	☐	
High Blood Pressure	☐	☐	
Bleeding disorders (eg: anaemia, anticoagulant treatment)	☐	☐	
Rheumatic Fever or Endocarditits	☐	☐	
Thyroid / other hormonal disorder	☐	☐	
Bronchitis	☐	☐	
TB	☐	☐	
Asthma	☐	☐	
Any other chest disease	☐	☐	
Chemotherapy / Radiotherapy	☐	☐	
Bone or joint disease? (e.g. Arthritis, osteoporosis) Bisphosphonate medication?	☐	☐	
Diabetes	☐	☐	
Eczema	☐	☐	
Dermatitis	☐	☐	
Epilepsy, Convulsions, Neurological disease	☐	☐	
Hepatitis	☐	☐	
HIV	☐	☐	
Liver or Kidney disease	☐	☐	
Learning difficulties	☐	☐	
Mental illness	☐	☐	
Bad reaction to anaesthetics	☐	☐	
Any other infectious disease	☐	☐	

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Are you:	No	Yes	If YES please give supporting details
Currently under care of a Doctor or hospital for **ANY** treatment?	☐	☐	
Taking **ANY** medicines prescribed or over –the-counter? (Incl. Use of steroids over the past 2 years)	☐	☐	
Allergic to any of the following: Penicillin	☐	☐	**Do you have any other Allergies?** No ☐ Yes ☐
Latex	☐	☐	If Yes please give details:
Chlorhexadine ('Corsodyl')	☐	☐	
If Female - could you be pregnant?	☐	☐	If yes - How many weeks? Due date:
Are you a nursing mother?	☐	☐	

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

Please note that we are required to update your Medical Questionnaire for each new course of treatment

Signature: Date:

Relationship to patient: