THE CALVERLEY DENTAL PRACTICE

Dental Medical History Questionnaire

In order to provide you with complete quality care, we require your medical history. All information provided will be treated in strictest confidence and available only to third parties you have consented to. Please complete as accurately as possible in BLOCK CAPITALS. Thank you.

Surname:…… First Name:…… (Dr/Mr/Mrs/Miss/Ms) D.O.B:……./……./……

Email address:……

Home address:……

Phone numbers: (Home)…… (Mobile)……

Occupation:……GP Name……

How did you hear about The Calverley Dental Practice (please tick):

- ☐ Family
- ☐ Internet
- ☐ Patient Referral
- ☐ Drove past surgery
- ☐ Radio
- ☐ Yellow Pages
- ☐ Other
- ☐ Staff Referral

Name of patient who referred you?……

Please circle which applies to you and provide details below:

High Blood Pressure	Yes	No	Depression	Yes	No
Artificial Joints	Yes	No	Other mental health issues	Yes	No
Asthma	Yes	No	History of HIV, Hep B or C	Yes	No
Bleeding Disorder	Yes	No	Lung Disorder	Yes	No
Cancer/Chemotherapy	Yes	No	Osteoporosis	Yes	No
Rheumatic Fever	Yes	No	Diabetes	Yes	No
Radiotherapy	Yes	No	Physically Disabled	Yes	No
Infective Endocarditis	Yes	No	Epilepsy	Yes	No
Reflux	Yes	No	Smoker	Yes	No
Heart Problems	Yes	No	Thyroid Disorder	Yes	No
Heart Valve Problem	Yes	No	Are you pregnant	Yes	No

Details:……

This form is a guide only and you should discuss any relevant matters with your Dentist prior to the commencements of any dental treatments.

Current Medications: (Prescription, over the counter, herbal) Yes/No
Details:……,……

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Allergies Yes/No Details:……

Is there any family history of Gum disease? Yes/No ……

Are you happy with the appearance of your teeth? Yes/No

If you answered No above, what would you like to improve?……

Signature_____Date_____