AVONDALE HOUSE DENTAL SURGERY
Confidential Patient Medical History Questionnaire

Name:……...
Date of Birth:……
Occupation:……
Doctor:……
Email Address:……

Please answer the following questions:

1. Approximate date of last dental examination:
2. Have you been seen by your doctor during the past year? Yes/No
3. Are you presently under medical care or taking ANY Medication? Please list.
4. Have you ever had a prolonged illness or hospitalisation? Yes/No
5. Have you ever had surgery or radiation therapy? Yes/No
6. Have you ever had any of the following:
   - Heart murmur
   - Rheumatic fever
   - Heart attack/angina
   - Heart defects/pacemaker fitted
   - Blood pressure: High/Low
   - Jaundice, Infective Hepatitis, Liver Disease
   - Diabetes – low blood sugar
   - Hiatus Hernia/Stomach trouble
   - Epilepsy
   - Asthma/Hayfever
7. Have you ever had any ill effects following dental treatment?
8. Have you or any relation had any prolonged bleeding problems? Yes/No
9. Have you ever had any bleeding problems following an extraction?
10. Do you have any sinus problems? Yes/No
11. Are you allergic to or are made ill by any medication?
12. Have you had any allergies? If so what are they?
13. Have you had any ill effects from penicillin or any other antibiotic?
14. Have you had any ill effects from local anaesthetic? Yes/No
15. Do you smoke? If so how many?
16. Do you have any blood disorders (tired blood)?
17. (women only) are you pregnant?
18. Is there any other information about your medical or dental history which may be important to us?
19. Have you ever had a blood transfusion or surgical treatment abroad? Yes/No
20. How much alcohol approximately do you consume per week?
21. (new patients only) How did you hear about the dental practice?

Date:…….. Signature:……