Patient Medical Questionnaire

Title: _____ Forename:_____ Surname: _____

Address:_____

Postcode:_____ Date of birth: _____

Phone No: (Home):_____ Work: _____

Mobile:_____ E-mail:_____

Occupation: _____

How did you hear about us? (Please circle):

Family / Friends Website Google Signage Outside Other:_____

Do you have or have you ever suffered from:	**Yes**	**No**
Rheumatic fever?	☐	☐
Any heart complaint – heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Any other serious illness? **(If Yes, please make additional notes below)**	☐	☐
Do you carry a medical warning card? **(If Yes, please make additional notes below)**	☐	☐
Are you allergic to any medicine, tablets, substances or latex?	☐	☐
Are you taking any medicine or tablets? (**If Yes, please list medication below**)	☐	☐
Are you pregnant?	☐	☐
In the past 2 years have you undergone any operation?	☐	☐
In the past 2 years have you been treated with hydro-cortisone or steroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or tell the dentist if you are HIV positive	☐	☐

What is your average weekly consumption of alcohol?.....

If you smoke, what is your average per week? .....

How would you rate your smile from 0-10? (0 = very unhappy, 10 = very happy) _____

Additional notes: _____

_____

_____

If you are not sure of any questions, or if your medical circumstances change, please inform the Dental Surgeon

Patient's signature:_____ Date:_____
(Parent or Guardian if patient under 16)

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Updated September 2021