The Terrace Dental Centre Medical Questionnaire

It is very important that we ask you to fill out the following questionnaire so that your individual treatment needs can be assessed **(All details are strictly confidential)**

Title (Mr/Mrs/Ms/etc) _____

Surname _____

First Name _____

Date of Birth _____

Address: _____

_____

Post Code: _____

Tel No: Home: _____
Work: _____
Mobile: _____

E-Mail Address: _____

Occupation: _____

Name and Address of your Doctor: _____
_____

Next of Kin _____
Address _____
Tel No: _____

Please tick the box if you DON'T wish to be contacted by email or mobile telephone ☐

Appointments that you have booked with us are confirmed by telephone.
Please tick the box if you DON'T want a message to be left on your home answerphone or with someone else. ☐

Have you ever suffered from?	*Yes*	*No*	*If yes, please give details*
Rheumatic Fever / Chorea			
Heart Disease / Heart Attack			
Heart Surgery / Pacemaker / Angina			
High Blood Pressure			
Chronic Asthma or Bronchitis			
Stomach Complaints			
Diabetes			
Epilepsy			
Blackouts / Giddiness / Fainting			
Excessive Bleeding			
Treatment with Steroids in last 2 years			
Hepatitis / Jaundice / Liver Disease			
Kidney disease			
Have you ever suffered from?	*Yes*	*No*	*If yes, please give details*

Any joint replacements			
Been exposed to HIV / TB / CJD			
Cold Sores			
Arthritis			
Are you pregnant			
Do you smoke – *please circle how many per day*			1 - 5 5 - 10 10 – 15 15 – 20 more than 20
What is your average intake of alcohol on a weekly basis *(please circle)*			None 1-5units 5-10 units 10-20 units Over 20 units

It is important that you tell us about any prescribed or self prescribed medication, for example homeopathic remedies or recreational drugs as this can affect your wellbeing.

	Yes	No	If yes, please give details
Are you taking any medication, ***please give full details of any prescribed or self administered drugs***			
Are you carrying a warning card			
Are you allergic to any medicines or tablets			
Any other allergies			
Any recent tests, medical treatment or previous operations			
Any serious illness			

Completed by: _____ Self/Parent/Guardian (Please circle) Date:_____

Updated on:	Any Changes	Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____