

## Confidential Medical Questionnaire

Name: ..... Date of Birth: .....

Have you ever had any of the following? Please tick

Allergies	Y	N	Heart Disease	Y	N
Anaemia	Y	N	Heart Murmur	Y	N
Asthma	Y	N	Hepatitis A B C	Y	N
Auto-Immune Disorders	Y	N	HIV / Aids	Y	N
Blood Disease	Y	N	Human Growth Hormone Treatment	Y	N
Blood Disorders	Y	N	Kidney Problems	Y	N
Blood Pressure	Y	N	Pacemaker	Y	N
Creutzfeldt-Jakob Disease (CJD)	Y	N	Pneumonia	Y	N
Diabetes	Y	N	Rheumatic Fever	Y	N
Dizziness	Y	N	Shortness of Breath	Y	N
Epilepsy / Fainting	Y	N	Stroke	Y	N
Head or Face Injury	Y	N	Swollen, Stiff, Painful Joints	Y	N
Are there any health matters which you would prefer to speak to the Dentist about?				Y	N

Past Medical History:

.....  
 .....

Do you have any other health problems not mentioned previously on this form?

.....

Have your Tonsils or Adenoids been removed?	Y	N	Have you had Tubes placed in the ears?	Y	N
Tendency for Colds or Sore Throats?	Y	N	Ear Infections?	Y	N
Do you take any medications?	Y	N	Please specify:		
Are you allergic to any medications?	Y	N	Please specify:		

Patient's Physician:

### Dental History

Has the patient ever sucked their thumb or finger?	Y	N	Age:	
Has the patient acquired any speech problems?	Y	N	Details:	
Does the patient breathe through the mouth?	Y	N	Details:	Day / Night
Has either parent had previous orthodontic treatment?	Y	N	Details:	
Has the patient had previous orthodontic treatment?	Y	N	Details:	
Has the patient played any musical instrument?	Y	N	Details:	
Have you consulted an Orthodontist or another Dentist regarding your orthodontic problems?	Y	N	Details:	
What is the patient's chief concern?				

I am aware that the information I have given is needed by the dental surgery in order to provide the safest possible dental care and that it is treated within the strictest of confidence within the practice. I have answered all of the questions honestly and am aware that I need to inform the staff of any changes at subsequent visits. I understand that I will need to sign this form again at each dental recall, indicating any changes that may have occurred.

Patient / Parent / Guardian's Signature: ..... Date: .....

Dentist's Signature: ..... Date: .....