Medical History Questionnaire

Edinburgh Dental
Oral Surgery & Implant Referral Clinic

Surname (Mr/Mrs/Miss/Ms) .....
Forename .....
Address .....
..... Postcode .....
Date of Birth (DOB) ..... Occupation .....
Telephone (home) ..... Mobile .....
Email Address .....

Certain medical conditions can affect dental treatment

Please complete this form by ticking the appropriate boxes and answering the questions below

All details will be strictly confidential

Do you have or have 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?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you allergic to any medicine, tablets, substances or latex? (list below)	☐	☐
at present taking any medicines or tablets? (List below in notes)	☐	☐
pregnant?	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
been treated with hydro-cortisone or corticosteroids?	☐	☐
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 day?	☐	☐

If 'Yes' to any questions please supply details in the 'Notes' below or use back of form

Name and address of your doctor: .....
.....
.....
.....

Notes: .....
.....
.....
.....

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

Patient Signature ..... Date .....

Where did you hear about us? .....

Are you interested in ☐ **White Fillings** ☐ **Dental Implants** ☐ **Cosmetic Braces**

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