coincidental

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v1.4

Name	
Address:	

Home Number	
Work Number	
Mobile Number	
Email Address	
DOB	

Medical & Dental Questionnaire

By filling out the following confidential questionnaire you will be greatly assisting us in our effort to provide the best dental treatment for you.Please answer the following questions as completely as possible.

- ☐ Arthritis
- ☐ Pacemaker / Heart surgery
- ☐ Hayfever, eczema, allerg
- ☐ Bronchitis, asthma, chest
- ☐ Fainting, giddiness, epilepsy
- ☐ Diabetes / Family member
- ☐ Bruise easily after extraction
- ☐ Excessive bleeder / Family
- ☐ Carry a warning card
- ☐ Antibiotic cover needed
- ☐ Pregnant
- ☐ Rheumatic fever / cholera
- ☐ Jaundice
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Taken steroids in last 2 years
- ☐ Oral Contraceptive Pill / HRT
- ☐ Smoker
- ☐ Had any blood test, Innoculations
- ☐ Hepatitis
- ☐ Heart murmur / Heart problem
- ☐ Angina / Blood pressure
- ☐ Heart attack / stroke
- ☐ Blood refused
- ☐ Are you HIV positive
- ☐ Joint replacement
- ☐ Osteoporosis / History in family
- ☐ Taking/taken Bisphosphonate
- ☐ Blood Clot
- ☐ Reaction to LA/GA
- ☐ Been hospitalised (please give details)
- ☐ Attending a Doctor (please give details)
- ☐ Under Medication (please give details)
- ☐ Allergic to Penicillin
- ☐ Serious illnesses (please give details)

☐ Method of Analgesia

Additional Medical Information

How did you hear about us?

Signed _____