

Health History Questionnaire

Confidential

Name:

(Mr/Mrs/Ms/Miss)..... Date of birth.....

BLOCK LETTERS

Address:.....

Home Phone:..... Work phone:.....

Email address:..... Mobile/Fax:.....

Do you want to receive your correspondence by email? Y N

Name of referring Dentist?.....

Name of family Doctor?.....

How did you hear about us? Yellow pages/White pages/Word of mouth/Referral/Other

Do you have Medical Insurance? Y N Name of Company and Policy.....

Is this consultation accident related? Y N Claim number and date of accident.....

Do you carry a specialist card/bracelet? Y N Please specify.....

What is your weight?..... What is your height?.....

HAVE YOU HAD ANY OF THE FOLLOWING? (CIRCLE Y/N)

Heart trouble or heart murmur? What and when? Y N

Rheumatic Fever? What and when? Y N

Jaundice or Hepatitis? What and when? Y N

Diabetes? When? Y N

Asthma? When? Y N

Have you ever had any serious illness? What and when? Y N

.....
If yes, were you treated in hospital? When?.....

Have you had any previous operations? What and when? Y N

Have you ever had a full General anaesthetic before? What and when? Y N

Do you have a history of fainting Y N

Are you taking any pills, tablets or medicine now or in the past 6 months?

What and when? Y N

Are you currently taking any herbal/natural remedies? Please specify Y N

Are you currently taking WARFRIN, CARTIA or ASPIRIN? Specify how many per day Y N

Have you ever taken FOSAMAX? Specify when.....

Do you use recreation drugs? Specify..... Y N

Are you a smoker? Number per day.....

HAVE YOU EVER HAD A REACTION TO ANY MEDICINES, INJECTIONS OR STICKING PLASTER?(penicillin or other antibiotic, aspirin, other tables or anaesthetics) please specify

..... Y N

Have you ever had a bad reaction during dental treatment? Specify Y N

Have you ever had a bleeding problem? What? Y N

Are you wearing an artificial or prosthetic joint? Specify type Y N

Have you any reason to believe that you may be at risk from HIV infection? Y N

Do you believe that you may be at risk from any other disease? Y N

Is there any other health matter your surgeon should know?

FEMALES

Are you pregnant? Y N

Are you on the oral contraceptive pill? Y N

Next of kin details:

Name: (Mr/Mrs/Ms/Miss)
Surname First Names

Relationship: i.e Mother/Father

Address:

Home phone: Work phone:.....

Email address Mobile/Fax

The medical history I have given is true and correct to my knowledge:

Signed: Date:

To be completed by the parent/guardian/caregiver if patient is UNDER 16 YEARS OF AGE

Name: (Mr/Mrs/Ms/Miss)
Surname First Names

Signed: DATE:

Medical update: I have read my Health History and confirm that is adequately states past and present conditions.

Date: Signed:

Date: Signed:

Date: Signed:

FINANCIAL AGREEMENT /TERMS OF TRADE

Please read carefully.

I understand that payment is due at the time of treatment unless other arrangements have been made.

By accepting services/treatment at this practice you agree to our terms of trade. I hereby agree inconsideration of credit being extended to me to pay ALL collection costs, court costs & solicitor fees in the event that this account becomes overdue.