

## Confidential Medical History Questionnaire

### Welcome

Welcome to Neil Markham & Associates Dental Practice, in order to help us meet all of your dental healthcare needs, please complete the following confidential medical history form. Please ask a member of our team if you need any further assistance or have any questions.

### Personal Details

Title  Mr  Mrs  Miss  Ms

Sex  M  F

Full Name

D.O.B

Home Tel.

Email Address

Occupation

Mobile Tel.

Please tick this box if you would prefer us not to contact you via email with special offers that we believe may be of interest to you

Address

Post Code

Approx. date of your last dental visit

### Doctor's Details

Name

Contact Tel.

Address

Post Code

### Medical History - Do you have or have you had any of the following:

	Yes	No		Yes	No
Anaemia?	<input type="checkbox"/>	<input type="checkbox"/>	Liver or kidney problems including hepatitis/ jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding after cuts, bruises or tooth extraction?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Blood refused by the Blood Transfusion Service?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer?	<input type="checkbox"/>	<input type="checkbox"/>	A joint replacement or other implant?	<input type="checkbox"/>	<input type="checkbox"/>
Brain surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Fainting attacks/ giddiness/ blackouts?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/ migraines?	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever?	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to local or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
Back trouble?	<input type="checkbox"/>	<input type="checkbox"/>	Treatment that required you to stay in hospital?	<input type="checkbox"/>	<input type="checkbox"/>
Eczema?	<input type="checkbox"/>	<input type="checkbox"/>	Please tick or tell your dentist if you are HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Or any of the following:	Yes	No	Do you have any close relatives with Creutzfeldt Jakob Disease?	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition including heart attack/ heart murmur/ angina?	<input type="checkbox"/>	<input type="checkbox"/>	Do you chew tobacco/ pan/ use gutkha or supari now (or have you in the past)?	<input type="checkbox"/>	<input type="checkbox"/>
High or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Growth hormone treatment before the mid 80's?	<input type="checkbox"/>	<input type="checkbox"/>
TB or chest problems including asthma/ bronchitis?	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever or Chorea/ St Vitus' Dance?	<input type="checkbox"/>	<input type="checkbox"/>			

