Lewes High Street Dental Practice
Medical Questionnaire
All details are on a need to know basis only and will be strictly confidential

Surname (Mr/Mrs/Miss/Ms) …….....
Forename(s) …….....
Address ……..…….....
.....Post Code……
Telephone No (Home)…….... Work……
Mobile……. Email …….
Occupation ……..... Date of Birth……

Have you suffered from? (*Certain medical conditions can affect dental treatment and vice versa).*

Rheumatic Fever? ……..YES/NO

Any heart complaint? (inc heart murmur) YES/NO
(if yes please list over)

Diabetes? ……....YES/NO

Epilepsy? …….….....YES/NO

Chronic bronchitis or asthma? …… YES/NO

Hepatitis ..... YES/NO

Excessive bleeding? …….. YES/NO

High blood pressure? …….. YES/NO

Any reason to feel at risk from CJD? YES/NO

Are you at present taking any medicines or tablets..... YES/NO
(if yes please list over)

In the past 2 years have you been treated with either hydrocortisone or corticosteroids?.....YES/NO

Have you been prescribed Bi-Phosphonates? YES/NO

Are you pregnant?.....YES/NO

Have you had a joint replacement Operation? YES/NO

Have you had any operations in the last two years? YES/NO

Have you ever smoked? .....YES/NO
(if yes, how many per day?) .....

Any other serious illness? ……....YES/NO
(if yes please list over)

How many units of alcohol do you drink a week?
..... units

Are you allergic to **anything** such as medicines, tablets or Latex etc?..... YES/NO
(if yes please list over)

Please delete as appropriate or **advise the dentist** if you are or maybe HIV positive?..... YES/NO

If **'yes'** to any of the questions, please supply details on the back of this form.

Please give the name & address of your Doctor.....
…….....

Patient's signature: ……..…… Date: ……..……

If you are not sure of any of the questions or if your medical circumstances change, please inform the Dentist immediately.