MEDICAL QUESTIONNAIRE

Surname……..... Initials……... Title…….

If YES, mark ☒ If NO, leave open

MEDICAL HISTORY

☐ Heart Disease
☐ Rheumatic fever
☐ High or low blood pressure
☐ Anaemia
☐ Blood clotting problems
☐ Hay fever
☐ Sinus problems
☐ Asthma

☐ Tuberculosis
☐ Lung problems
☐ Kidney problems
☐ Diabetes
☐ Are you taking any medicine regularly?

☐ Jaundice or liver problems
☐ Porphyria
☐ Epilepsy
☐ Do you often get headaches?
☐ Hormonal problems
☐ Arthritis
☐ Do you take cortisone?
☐ Are you allergic to anything?
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☐ Are you more tense than normal?
☐ Replacements like shoulder/knee/hip/heart
☐ Do you smoke?
☐ Aids

Specify…….....

Have you had any other serious disease? / Serious operation / Replacement operations like shoulder/knee/hip/heart valve?

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Females: Are you pregnant? ☐ How many months?

B. DENTAL HISTORY

What is your main complaint or purpose of this visit?

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Have you experienced any abnormal reactions with dental injections?
Have you any discomfort or pain in your mouth**?**
Do your gums ever bleed**?**
Do you have frequent ulcers in your mouth?
Have you noticed any loose teeth?
Have you noticed any odours or a bad taste?
Are you conscious of any mouth habits, e.g. clenching or grinding?
Do you experience pain in the joints of your jaw?
Have you had any gum treatment or operations?
Have you experienced any abnormal bleeding after extractions?
Have you had orthodontic treatment?
Do you wear a denture?
Has a dentist or oral hygienist shown you to clean your teeth?

In case of any change in the above information, please notify us.