Medical History Questionnaire

Hywel Samuel & Associates
deintyddfa
dental practice

Surname (Mr/Mrs/Miss/Ms): .....

Forenames:

Address:

Postcode: Email:

Tel No: Mobile No:

Date of Birth: Occupation:

Height: Weight: BMI:

I give my consent to my contact details being used for the following : (please click relevant box)

Practice Communications (Appt reminders, etc.) Email ☐ sms ☐

Marketing Communications Email ☐ sms ☐

Certain medical conditions can affect dental treatment and vice versa

Please complete this form by ticking the appropriate boxes and answering the questions.

All details will be strictly confidential.

Do you have or have you every suffered from:	**yes**	**no**
Rheumatic fever?	☐	☐
Any heart complaint, heart surgery or stroke?	☐	☐
Diabetes?	☐	☐
Epilepsy or fainting attacks?	☐	☐
Chronic bronchitis or asthma?	☐	☐
Hepatitis?	☐	☐
Excessive bleeding?	☐	☐
High blood pressure?	☐	☐
Any other serious illness?	☐	☐
Do you carry a medical warning card?	☐	☐
Are you allergic to any medicine, tables, substances or latex? (list below in notes)	☐	☐
…at present taking any medicine or tables? (list below in notes)	☐	☐
…pregnant	☐	☐
In the past 2 years have you undergone any operations?	☐	☐
…been treated with hydro cortisone or corticosteroids?	☐	☐
Have you ever had a joint replacement operation?	☐	☐
Please tick or tell the dentist if you are HIV positive	☐	☐
What is your average weekly consumption of alcohol?	☐	☐
If you smoke, what is your average per week?	☐	☐

If '**yes**' to any questions, please supply details below:
NOTES:

Name and address of your doctor:

How did you hear about us?

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

Patients signature: Date:

Please complete and email to: mailto:admin@hywelsamuel.co.uk