canada water dental health

REGISTRATION/MEDICAL HISTORY QUESTIONNAIRE (Adult)

Mr/Mrs/Miss/Ms Surname..... Email.....
Forename(s).....Address.....
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Post Code..... Tel (Home)..... Tel (Work).....
Date of Birth..... Occupation.....

Certain medical conditions can affect dental treatment and vice versa

Please complete this form as accurately as possible. All details will be kept strictly confidential.

Please answer yes or no to the following questions. *(For any questions you answer 'Yes' that require more information please state an answer on the line below)*

Are you receiving treatment from a doctor, hospital or clinic?	Yes	No
Are you taking prescribed medicines?	Yes	No
Do you carry a warning card?	Yes	No
Do you take steroids now or have you in the past 3 years?	Yes	No
Any allergies to medicines or substances?	Yes	No
Hay fever or eczema?	Yes	No
Bronchitis, asthma or other chest condition?	Yes	No
Fainting attacks, giddiness, black outs or epilepsy?	Yes	No
Heart problems, blood pressure, angina or stroke?	Yes	No
Diabetes or in the family?	Yes	No
Arthritis?	Yes	No
Bruising or persistent bleeding following an injury?	Yes	No
Any Infectious Diseases? (including Hepatitis, HIV, CJD)	Yes	No
Blood refused by blood transfusion service?	Yes	No
A bad reaction to general or local anaesthetic?	Yes	No
A joint replacement or other implant?	Yes	No
Treatment that required you to be in hospital?	Yes	No
Heart surgery?	Yes	No
Brain surgery?	Yes	No
Growth hormone treatment before mid 80's?	Yes	No
A close relative with CJD?	Yes	No
Are you self medicating or taking recreational drugs?	Yes	No

Addition Medical Notes

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