WELCOME________________________________
thank you for selecting brighton white

medical history questionnaire

Surname (Mr/Mrs/Miss/Ms)……………………………………………………………..
Forename……………………………………………………………………………
Address……………………………………….Postcode……………………………
Tel no. (home/work)………………………….Tel no. (Mobile)……………………
Date of Birth………………………………………………………………………
Exemption/Dental Insurance………………………………………………………
Name&address of your doctor Notes
………………………………………….. ………………...............................
………………………………………….. ……………………………………...
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Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions;

Have you ever been hospitalized or had a major operation?..Yes/No
If yes, please explain……………………………………………………………………………
Have you ever had a serious head or neck injury?...Yes/No
If yes, please explain…………………………………………………………………………..
Are you taking any medications, pills or drugs?...Yes/No
If yes, please explain……………………………………………………………………………
Do you use tobacco?..Yes/No
Do you use controlled substances?...Yes/No
Pregnant/Trying to get pregnant? Nursing?..Yes/No
Do you snore?... Yes No

Are you allergic to any of the following?
Aspirin/ Penicillin /Codeine/ Acrylic/ Metal/ Latex/ Local
Anesthetics/Others…………………………………………………………………

Do you have or have you had any of the following?..Yes/No

AIDS/HIV Positive/ Chest Pains /Frequent Headaches/ Irregular Heartbeat/ Kidney Problems/Congenital Heart Disorder/ Anemia Convulsions Hay Fever Liver Disease Sinus Trouble/ Heart Attack/Failure Low Blood Pressure /Arthritis/ Diabetes /Heart Murmur / Lung Disease Stomach/Intestinal Disease Artificial Heart Valve/ Drug Addiction /Heart Pace Maker/ Heart Trouble/Disease Pain in Jaw Joints Swelling of Limbs Asthma Emphysema Hemophilia Parathyroid Disease Thyroid Disease Blood Disease /Epilepsy or Seizures/ Hepatitis A /Psychiatric Care/ Tonsillitis Blood Transfusion/ Excessive Bleeding/ Hepatitis B or C /Radiation Treatments/ Tuberculosis Breathing Problem / Tumors /Bruise Easily/ Fainting Spells/Dizziness High Blood Pressure Renal Dialysis/ Ulcers /Cancer /Frequent Cough/ Hives or Rash Rheumatic Fever /Venereal Disease /Chemotherapy / Yellow Jaundice
Have you ever had any serious illness not listed above?
If yes, please
explain………………………………………………...
....
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient.s) health. It is my responsibility to inform the dental office of any changes in medical status.

Patients Signature…………………………………..Date………………………………………..