FOX LANE DENTAL CARE
CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Tel: 020 8886 0325
patientcare@foxlanedentalcare.co.uk
www.foxlanedentalcare.co.uk

YOUR PERSONAL DETAILS

SURNAME:			Forenames:	
DATE OF BIRTH:			Address: Post Code: Email address: Occupation:	
Are you receiving any state benefits or Do you have Private Dental Insurance? YES / NO				
IF YES, WHICH BENEFITS OR INSURANCE?				
Phone: (Home)	(Mobile)	(Work)	National Insurance No	
Your Doctor's name and address (GP)			How did you hear about us? Word of Mouth / Internet / GP (Doctor) / Other	

QUESTIONS ABOUT YOUR *CURRENT* MEDICAL HEALTH	YEAR OF DIAGNOSIS	YES	NO
Are you undergoing any medical treatment at the moment?			
Do you have or have you had any of the following: *(Please circle appropriate answers)			
Heart disease, Heart failure, Heart operations or Pacemaker *			
High Blood Pressure			
High Cholesterol			
Hepatitis A, B, C or other *			
Liver or Kidney Disease, jaundice or Dialysis *			
Epilepsy, Migraines or Panic Attacks *			
Stroke or Bran Haemorrhage *			
Diabetes – Type 1 or 2 *			
Thyroid disease, Scleroderma or Psoriasis *			
Anaemia, Thalassaemia or Thalassaemia carrier *			
Pneumonia, Chronic Bronchitis or other lung condition *			
Asthma, Hay fever or Chronic Sinusitis *			
Hereditary or acquired bleeding problems *			
Any other serious illness or condition			
Have you previously experienced excessive bleeding after injury or tooth removal?			
Have you previously experienced a bad reaction to local anaesthetic?			
Have you previously been treated with Penicillin?			
Are you allergic to Penicillin or Amoxicillin or any other medication?			
Are you pregnant or breastfeeding a newborn baby?			
Are you on the contraceptive pill or Hormone Replacement Therapy (HRT)?			
Have you or a close relative been diagnosed with CJD (Human form of Mad Cow's Disease)?			
In the past 5 years, have you been treated with any of the following medicines?			
Cortizone (Predisolone)			
Blood Thinners (Warfarin)			
Antidepressants			
Do you carry a Medical Warning Card for any condition?			
Have you ever received Radiotherapy or Chemotherapy? *			
How much of the following do you consume per week			
Alcohol How many units/pints/glasses per week			
Fizzy drinks How many cans/litres per week			
Sweets/Chocolates/sugar spoons in tea/coffee per week			
Do you smoke? Yes/No If yes, how many per day?			
Are you presently taking any medication? Yes/No			
Please list your medication below and any other information you would like to tell us (continue overleaf)			

IS THERE AN OTHER INFORMATION THAT YOU WOULD LIKE TO TELL THE DENTIST IN CONFIDENCE? YES NO

FORM COMPLETED BY: _____ DATE: _____

DENTIST SIGNATURE: _____

☐ **Please tick this box to consent to your information being used as laid out in our practice Privacy Policy**

(ALL INFORMATION CONTAINED IN THE FORM WILL BE TREATED WITH THE STRICTEST CONFIDENCE AT ALL TIMES BY ALL MEMBERS OF THIS PRACTICE).