THE DENTAL PRACTICE - SHENFIELD
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name & Surname: ☐ M ☐ F **Address:** **Home Tel:** **E-mail:** **Mobile:**	**DOB:** **Profession:** **Work Tel:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Name of your GP:	**Tel. of your GP:**

PERSONAL HEALTH HISTORY

List any medical problems that your GP have diagnosed, that we should be aware off:

HEALTH HABITS & PERSONAL

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, how many units per week?		
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
Personal	Female patients: Are you pregnant	☐ Yes	☐ No

MEDICAL HISTORY

Have you ever had any of the following:		
ANAMEMIA	☐ Yes	☐ No
HEART DISEASE	☐ Yes	☐ No
HIV POSITIVE	☐ Yes	☐ No
RHEUMATIC FEVER	☐ Yes	☐ No
JAUNDICE, LIVER PROBLEMS, HEPITITIS	☐ Yes	☐ No
HIGH OR LOW BLOOD RESURE? IF YES, WHICH ONE?	☐ Yes	☐ No
PORPHYRIA	☐ Yes	☐ No

EPILEPSY	☐ Yes	☐ No
BLOOD CLOTTING PROBLEMS	☐ Yes	☐ No
SUFFER FROM HEADACHES?		

HAY FEVER OR OTHER ALLERGIES? ……	☐ Yes	☐ No
HORMONAL PROBLEMS	☐ Yes	☐ No
ASTHMA	☐ Yes	☐ No
TUBERCULOSIS	☐ Yes	☐ No
LUNG PROBLEMS OR DISEASE	☐ Yes	☐ No
DIABETES	☐ Yes	☐ No
DO YOU SMOKE?	☐ Yes	☐ No
ARE YOU MORE STRESSED THAN NORMAL?	☐ Yes	☐ No
ARE YOU TAKING ANY MEDICATION OR TABLETS REGULARLY	☐ Yes	☐ No
HAVE YOU BEEN ADVISED IN THE PAST TO TAKE ANTIBIOTICS PRIOR TO DENTAL TREATMENT?	☐ Yes	☐ No

Date: …… Patient Signature: ……

Medical Update:

Date: …… Changes Yes / No: …… Patient Initials: ……

Date: …… Changes Yes / No: …… Patient Initials: ……

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