At Home Dental, 24 Bridgetown, Totnes TQ9 5AD **Tel: 07960 908586**

Please complete this **IMPORTANT** and **CONFIDENTIAL** medical questionnaire so that the dentist can treat you safely. Continue overleaf if necessary.

Please complete this prior to your dental visit

Patient's Name .....
Date of Birth .....
Address .....
.....
.....
Tel. no(s) .....
Mobile Number .....
Name and address of your doctor .....

Do you have, or have you ever had (tick Yes or No):

	Yes	No
Angina	☐	☐
A heart attack	☐	☐
Any other heart problems e.g. endocarditis, surgery	☐	☐
Blood pressure trouble	☐	☐
Rheumatic fever	☐	☐
A stroke	☐	☐
A bleeding/clotting disorder	☐	☐
Epilepsy	☐	☐
Diabetes	☐	☐
Kidney trouble	☐	☐
Liver trouble	☐	☐
Breathlessness	☐	☐
Asthma	☐	☐
Allergy to penicillin	☐	☐
Allergy to anything else e.g. latex, medications	☐	☐
Reason to believe that you might have HIV/AIDS	☐	☐
Reason to believe that you might have a hepatitis virus	☐	☐
Steroids (other than skin creams) within the last 12 months	☐	☐
Anticoagulants (e.g. Warfarin) within the last 12 months	☐	☐
Medications for bone cancer or osteoporosis	☐	☐
Reason to believe that you are at risk of CJD/vCJD	☐	☐
Dementia	☐	☐
Alzheimer's disease	☐	☐
Serious illness	☐	☐
Any serious operations	☐	☐
Do you use tobacco	☐	☐ If yes, how much?.....
Have you used tobacco in the last ten years	☐	☐
Do you drink more alcohol than the recommended limit?	☐	☐ If yes, how much?.....
Are you currently ill?	☐	☐ If yes, please give details overleaf.
Are you currently pregnant or breast feeding ?	☐	☐
Is there a Do Not Resuscitate order in place?	☐	☐

Please list here any medications you currently take:

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Continue overleaf if necessary.

Do you consent to us taking photographs for clinical purposes (diagnosis / treatment planning / record or treatments completed)? YES / NO (Please Circle)

Do you consent to us contacting you via email, text message and/or post for marketing and health education purposes? YES / NO (Please Circle)

PLEASE TURN OVER

If we are unable to contact you directly, do you consent to us discussing your treatment with anyone else?

YES / NO (Please Circle)

Please give details below: -

Name…… Contact Number……

Address…… Email Address…….

……

……

……

Thank you. Now please sign.

I am the patient/ I am signing on the patient's behalf (delete as appropriate)

Signature…….Date…… (A.O.R ☐)

Please use this space if there was insufficient space overleaf