o3 dental
implants | cosmetics | excellence

Dr PD Flanagan
BDS, BSc(Hons), FDSRCS(Eng), MFGDP, DipImpDentRCS(Eng) Adv.Cert.

MEDICAL HISTORY QUESTIONNAIRE

Surname (Mr/Mrs/Miss/ Ms)……
Forename……
Address……
Postcode……Email……
Tel No.(day)……Tel No.(evening)……
Date of Birth……Occupation……

Certain Medical conditions can affect dental treatment and vice versa
Please complete this form by indicating Yes or No and answering the questions

All details will be strictly confidential
Do you have or have you ever suffered from:

Rheumatic fever?……Yes/No
Any heart complaint, heart surgery or stroke?……Yes/No
Diabetes?……Yes/No
Epilepsy of fainting attacks?……Yes/No
Chronic bronchitis or asthma?……Yes/No
Hepatitis?……Yes/No
Excessive bleeding?……Yes/No
High blood pressure?……Yes/No
Any other serious illness?……Yes/No
Do you carry a medical warning card?…… Yes/No
Are You allergic to **any** medicine, tablets, substances or latex? (list below)
at present taking any medicine or tablets? (list below)……Yes/No
pregnant?……Yes/No
In the past 2 years have you undergone any operations?……Yes/No
been treated with hydrocortisone or corticosteroids?……Yes/No
Have you ever had a joint replacement operation?……Yes/No
Please tick or **tell the dentist** if you are HIV positive……Yes/No
What is your average weekly consumption of alcohol?……
If you smoke, what is your average per week?……
If "yes" to any questions please supply details below in "Notes"

Name and address of your doctor:	**Notes:**
……	……
……	……
……	……
……	……
……	……

If you are unsure of any questions, or if your medical circumstances change, please tell the dentist.

Patient signature……Date……