North Street Dental Practice Health Questionnaire - CONFIDENTIAL

Personal Details					
Title:	Forename:	Surname:		Date of Birth:	
Address:					
			Post Code:		
Occupation:					
Telephone & Email Contact Numbers					
Home ☎		Mobile ☎		Work ☎	
Email					
Next of Kin Details – Emergency Use Only					
Title:	Forename:	Surname:			
Home ☎		Mobile Work ☎			
GP Details:					
Drs Name:		Drs Telephone Number ☎			
Drs Surgery Name:					
Address:					
			Post Code:		
Nominated Person who the Practice can talk to on your behalf:					
Title:	Forename:	Surname:		Date of Birth:	
I give consent to receiving mobile phone texts				Please Initial:	
I give consent to receiving emails including marketing emails from the Practice				Please Initial:	

Please Read Carefully and Answer ALL Questions.

Lifestyle – Do you take/use or are you?					
Smoke - Specify per day			Chew tobacco – Specify		
Alcohol (Units per week)			Recreational drugs	Yes □	No □
Pregnant	Yes □	No □	Have a high sugar diet	Yes □	No □
Do you drink fizzy drinks?	Yes □	No □	Amount per week - Specify		
Heart - Do you or have you had any of the following?					
Rheumatic fever	Yes □	No □	Angina	Yes □	No □
High blood pressure	Yes □	No □	Low blood pressure	Yes □	No □
Previous heart surgery	Yes □	No □	Atrial fibrillation	Yes □	No □
Heart attack	Yes □	No □	Heart murmur	Yes □	No □
Pacemaker fitted	Yes □	No □	Previous stroke	Yes □	No □
History of blackouts	Yes □	No □	Dizziness	Yes □	No □
Other heart conditions – Specify					
Chest/ Lung - Do you or have you had any of the following?					
Asthma	Yes □	No □	Emphysema/COPD	Yes □	No □
Bronchitis	Yes □	No □	Pneumonia	Yes □	No □
Cystic fibrosis	Yes □	No □	Tuberculosis	Yes □	No □
Pleurisy	Yes □	No □			
Other chest/lung conditions – Specify					
Blood Conditions - Do you or have you had any of the following?					
Bruise easily	Yes □	No □	Anaemia	Yes □	No □
Haemophilia	Yes □	No □	Sickle cell anaemia	Yes □	No □
Previous abnormal blood test	Yes □	No □			
Have you been tested for: Hepatitis A, B, C, HIV	Yes □		No □		
Other blood conditions – Specify					

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Other medical conditions - Do you or have you had any of the following?					
Kidney disease	Yes □	No □	Liver disease	Yes □	No □
Epilepsy	Yes □	No □	Migraines	Yes □	No □
Diabetes Yes □ No □	Insulin controlled Yes □		Tablet controlled Yes □	Diet controlled Yes □	
Allergies - Do you have, or have you had reactions to any of the following?					
Penicillin	Yes □	No □	Latex	Yes □	No □
Hay fever	Yes □	No □	Medicines – Specify below	Yes □	No □
Eczema	Yes □	No □	Nuts	Yes □	No □
General anaesthetic	Yes □	No □	Aspirin	Yes □	No □
Local anaesthetic	Yes □	No □	Do you carry an EpiPen	Yes □	No □
Other Allergies – Specify					
Warnings – Do you have or previously had any of the following?					
BISPHOSPHONATES	Yes □	No □	Back or Joint problems	Yes □	No □
Arthritis	Yes □	No □	Osteoporosis/Bone problems	Yes □	No □
Hearing impairment	Yes □	No □	Sight impairment	Yes □	No □
Acid reflux	Yes □	No □	Hiatus hernia	Yes □	No □
Alzheimer's	Yes □	No □	Dementia	Yes □	No □
Antibiotic cover	Yes □	No □	Treated for cancer previously	Yes □	No □
History of falling	Yes □	No □	History of cold sores	Yes □	No □
Difficulties lying flat	Yes □	No □	History of anxiety/ depression	Yes □	No □
Medications – Are you taking, using currently or previously had?					
Contraceptive pill	Yes □	No □	Steroids – Last 2 years	Yes □	No □
Previous radiotherapy	Yes □	No □	When?		
Previous chemotherapy	Yes □	No □	When?		
Are you receiving any hospital treatment at present? – Specify					
Any other health warnings or relevant information that your dentist should be aware of? – Specify					

Other medications – Specify below		
Drug	**Dose**	**Frequency**

Please Bring Your Repeat Prescription with you to your next visit

Signature of Patient/Parent/Guardian…… Date……..

Signature of Dentist…….. Date……..

I have reviewed the above and I can confirm that there have been no changes to any of the information that I have provided.

Signature of Patient/Parent/Guardian…… Date……..