Barton Dental Surgery

Medical History Questionnaire

When was your last visit to the dentist?.....

Are you having any gum pain/toothache at this time? Yes No

Do you feel nervous about having dental treatment? Yes No

Have you been a patient in hospital or consulted your doctor about any serious illness during the past two years? Yes No

To the best of your knowledge are you a carrier or either Hepatitis (any group) or HIV (an answer of yes will not disqualify you from treatment)? Yes No

Have you had any other serious illness? Yes No
If yes, please specify…….

Have you taken any drugs (Prescribed or non-prescribed) or medicines regularly for any period during the past two years? Yes No
If yes, please specify…….

Are you allergic to penicillin, aspirin or any other drugs or medicines? Yes No
If yes, please specify…….

Have you ever had excessive bleeding requiring special treatment? Yes No

Are you pregnant? Yes No
If yes do you have a due date:……

Are you taking the contraceptive pill? Yes No

Do you smoke? Yes No

Do you drink alcohol? Yes No

Who is your doctor at present?.....

I declare that to the best of my knowledge the information I have given above is true and correct.

Signature…… Date…….

Print Name……