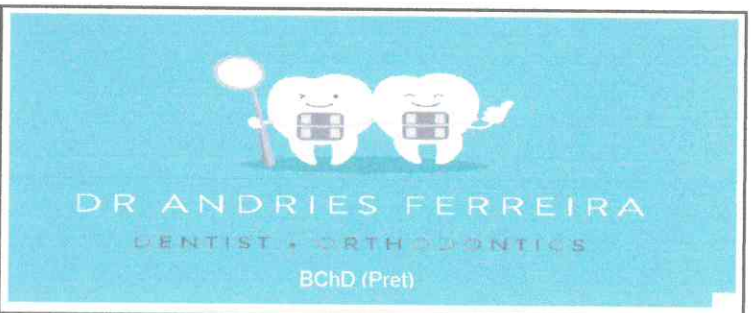
DR A FERREIRA

MEDICAL HISTORY QUESTIONNAIRE



Title: Dr / Mr / Mrs / Miss/ Other		ID	
INITIALS AND SURNAME			
FIRST NAMES			
PREFERRED NAME		GENDER	M F
MOBILE		WORK	
HOME		OTHER	

MEDICAL QUESTIONNAIRE - PRIVATE AND CONFIDENTIAL

Please answer these questions fully or discuss them with your dentist. Information about your medical history is for your dentist's use only.

PAST / CURRENT MEDICAL CONDITIONS

Medical practitioner		TEL. NO.	
ALLERGIES	Y N	DETAILS	
Have you had any serious or long standing illness			
Have you ever been hospitalised			
Cronic medicines			

Please indicate if you EVER had any of the following:

Any heart complaint/treatment	Y	N		Tuberculosis (TB)	Y	N		
Rheumatic fever	Y	N		Any nervous system disorder	Y	N		
Heart valve surgery	Y	N		Gastric ulcer	Y	N		
High blood pressure	Y	N		Asthma	Y	N		
Low blood pressure	Y	N		Lung condition	Y	N		
Blood disorders	Y	N		Radiation therapy / chemotherapy	Y	N		
Anti-coagulant therapy	Y	N		Thyroid disease	Y	N		
Joint replacement surgery	Y	N		Hepatitis, jaundice	Y	N		
Osteoporosis or low bone density	Y	N		Liver disease	Y	N		
Epilepsy	Y	N		Treatment for any form of cancer	Y	N		
Diabetes	Y	N		Transplanted organ/bone marrow	Y	N		
HIV	Y	N		Pregnant (when due)	Y	N		
High cholesterol	Y	N		OTHER:				
Do you smoke?	Y	N						

I declare that the above is a true and accurate record. This form is a guide only and you should discuss any relevant matters with your dentist prior to the commencement of any dental treatments.

SIGNATURE:		**DATE:**	2 0