The White House Dental Practice

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Confidential Medical History Questionnaire

Personal Details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ______ Sex: ☐ M ☐ F

Full Name ______ D.O.B ______ Home Tel. ______ Work Tel. ______

Email Address ______ Occupation ______ Mobile Tel. ______

Address ______ Post Code ______

How would you prefer to receive correspondence from The White House Dental Practice?

☐ By email ☐ By post ☐ By SMS

Approx. date of last dental visit? ______

Doctor's Details

Name and Address ______ Contact Tel. ______

Medical History - Do you Have or Have you Had any of the Following?

	Yes	No		Yes	No
Anaemia			Heart condition or heart attack/ heart murmur/ angina		
Diabetes			Rheumatic fever		
Epilepsy			Liver or kidney problems including hepatitis/ jaundice		
Cancer			TB or chest problems including asthma/ bronchitis		
Brain surgery			A joint replacement or other implant		
Arthritis			Bad reaction to local or general anaesthetic		
Cold sores			Blood refused by the Blood Transfusion Service		
Gastric disease			Treatment that required you to stay in hospital		
Drug dependence			Please tick or tell your dentist if you are HIV positive		
High blood pressure			Women only:		
Fainting attacks/ giddiness/ blackouts			Are you taking the contraceptive pill?		
Migraines			Are you pregnant?		

Are you allergic to any medicines, tablets, substances or latex? If so, which? ______

Do you smoke? If so, how many cigarettes do you smoke on average in a day? ______

On average, how many units of alcohol do you drink in a week? ______

Please list any medication you are currently taking:

______

Please turn over »

How did you hear about us? (If referred, please state by whom)

☐ In passing ☐ Advert ☐ Web ☐ Family/ friend ☐ Referral ☐ Other

Please provide further details

Signature

Please sign below to certify that you have read and understood the above information and that all your answers are accurate and up-to-date. Any incorrect information can be dangerous to your health and you must inform us of any changes.

Patient/ Parent/ Guardian

Date: / /

Medical History Form Updates (For Follow-up Appointments)

Please sign below to certify that the information in this Medical History Form is still accurate and up-to-date. If there are any changes in your health, please provide us with details.

Patient/ Parent/ Guardian

Date: / /

Please either state ‘No Changes’ or provide details of changes

Patient/ Parent/ Guardian

Date: / /

Please either state ‘No Changes’ or provide details of changes

Patient/ Parent/ Guardian

Date: / /

Please either state ‘No Changes’ or provide details of changes

The purpose of processing your personal data is to provide you with optimum dental health care and prevention.

Your personal data will be processed according to our Privacy Notice Policy and to the EU General Data Protection Regulation (GDPR), which can be found on our website: www.thewhitehouse.dental