HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL - PLEASE ANSWER ALL QUESTIONS

Name: ..... Date of Birth: / /
(Title) (Surname) (Given name)

Address: .....

.....

Home no.: ..... Work no.: .....

Mobile no.: ..... Email: .....

Name and address of referring doctor or dentist:

.....

Name and address of doctor:

.....

	PLEASE CIRCLE
Is this consultation related to an ACC claim?	Yes / No
Do you have private medical insurance?	Yes / No
Are you being treated for any medical condition at present?	Yes / No
Do you carry a special health card or medic alert bracelet?	Yes / No

Have you ever had any of the following?

Heart trouble or heart murmur	Yes / No	Rheumatic Fever	Yes / No
Artificial heart valve	Yes / No	Bleeding disorder	Yes / No
Jaundice or Hepatitis	Yes / No	Diabetes	Yes / No
Fits or Epilepsy	Yes / No	Asthma	Yes / No
Artificial joint replacement	Yes / No	Other serious illness	Yes / No

If YES to any of the above, please provide details:

.....

.....

Have you ever had a General Anaesthetic?	Yes / No
Have you ever had any previous operations?	Yes / No
Have you ever had treatment or taken medication to prevent bone loss or correct osteoporosis?	Yes / No
Have you taken any tablets or medicines (including non-prescription) in the last 6 months?	Yes / No

If YES, please list:

.....

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Have you ever had a reaction to any of the following?

Penicillin or other antibiotics, aspirin or any other tablets	Yes / No
Any medicines, injections or sticking plaster	Yes / No

Have you ever had a bad reaction during dental treatment?	Yes / No
Have you ever had any reason to believe that you may be at risk from HIV Infection?	Yes / No
Do you smoke?	Yes / No

Females

Are you pregnant?	Yes / No
Are you taking the Oral Contraceptive Pill?	Yes / No

The information I have given is true and correct to the best of my knowledge.

Signed: ..... Date : / /

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