SnoringSolutionsNI
ADJUSTABLE PRECISION SNORING APPLIANCES

confidential medical history

To offer the best and most appropriate dental care please provide us with as much detail as possible about your medical history.

Please complete all questions.

Title _____ Full Name _____

Date of Birth _____

Address _____

_____

Postcode _____ Home No _____

Mobile No _____ Work No _____

Email _____

Occupation _____

Name and address of your doctor _____

_____

_____

How did you hear about the practice? ☐ Friend/Family ☐ Social Media ☐ Website

If other please can you tell us

_____

Are you:	**Select**	**Details**
Receiving treatment from your doctor or hospital?	☐ Yes/No ☐	
Pregnant or likely to be so?	☐ Yes/No ☐	
Taking any medication?	☐ Yes/No ☐	

(e.g. tablets, ointments, inhalers - including contraceptives and hormore replacement therapy)

Please list medication below:

_____

_____

_____

_____

_____

_____

_____

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Have you:	Select	Details
any allergies (eg penicillin, substances (eg latex, rubber) or foods?	☐ Yes/No ☐	
heart problems, heart surgery, angina, blood pressure problems, or stroke?	☐ Yes/No ☐	
had rheumatic fever or chorea?	☐ Yes/No ☐	
had liver disease (eg jaundice, hepatitis) or kidney disease?	☐ Yes/No ☐	
asthma, bronchitis, or other chest conditions?	☐ Yes/No ☐	
ever had a blood refused from the Blood Transfusion Service?	☐ Yes/No ☐	
ever had a bad reaction to general or local anaesthetic?	☐ Yes/No ☐	
any close relative (parent, sibling, child, grandparent or grandchild) with Creautzfeldt Jakob disease?	☐ Yes/No ☐	
arthritis?	☐ Yes/No ☐	
a joint replacement or other implant?	☐ Yes/No ☐	
any other serious illness?	☐ Yes/No ☐	

Do you:	Select	Details
experience fainting attacks, giddiness, blackouts or epilepsy?	☐ Yes/No ☐	
carrying a medical warning card?	☐ Yes/No ☐	
bruise or bleed excessively following injury, tooth extraction or surgery?	☐ Yes/No ☐	
smoke any tobacco products now (or did you in the past)?	☐ Yes/No ☐	
regularly drink more than 21 units of alcohol per week?	☐ Yes/No ☐	
suffer from infectious diseases (including HIV and hepatitis)?	☐ Yes/No ☐	
Are you diabetic (or is anyone in your family)?	☐ Yes/No ☐	
Is there any other information which your dentist might need to know about, such as self-prescribed medicines (eg aspirin)?	☐ Yes/No ☐	
snore?	☐ Yes/No ☐	
feel tired during the day?	☐ Yes/No ☐	

Signature _____ Date _____