

CONFIDENTIAL HEALTH QUESTIONNAIRE

Name: _____
Mr/Mrs/Miss/Ms

Address: _____

Telephone: _____ Home
_____ Mobile
_____ Escort's Contact Number

Date of Birth: _____ Occupation: _____

Medical Practitioner: _____

In order to provide the best and safest dental treatment we need to know of any medical problems which may affect your treatment. Please tick the box only if the answer is yes.

1. Are you presently receiving medical treatment? []
2. Have you ever been admitted to hospital? []
3. Do you or have you ever had and of the following?

Rheumatic Fever	[]	Epilepsy	[]
Heart Trouble	[]	Anaemia	[]
High Blood Pressure	[]	Bleeding Disorders	[]
Asthma	[]	Tuberculosis	[]
Arthritis	[]	Gastric Problems	[]
Hepatitis	[]	Cold Sores	[]
Bronchitis/Chest Problems	[]	Depressive Illness	[]
Migraine Headaches	[]	Kidney Trouble	[]
Diabetes	[]	Drug Dependence	[]
HIV/AIDS	[]	Other	[]
4. Are you taking any tablets, medicines or drugs? []
If so please list: _____

5. Are you allergic to any medications? []
If so please list: _____
6. Are you wearing an artificial or prosthetic joint? []
7. Have you ever experienced excessive bleeding or bruising from cuts, scratches or dental treatment? []

8. Have you ever had contact with the AIDS/HIV virus? []

9. Have you ever had a reaction to an anaesthetic? []

10. Women: Are you pregnant at the moment? [] weeks []

11. Can you easily walk up two flights of stairs without stopping? Yes [] No []

Is there anything else regarding your health that you think we should know about?

Name of parent or guardian for patients under 16 years: _____

CONSENT

1. The medical history I have given is true and correct to my knowledge, and I have disclosed all medications including over-the-counter and herbal remedies that I am taking.

2. I consent to Dr Kofi Oteng-Boateng performing the following procedure:

It has been explained and I have understood the complications of such procedures under: Local Anaesthetic / Local Anaesthetic and Intravenous Sedation. I have had adequate opportunity to ask questions and have received all the information I want. I understand that I am welcome to ask for more information if I wish.

3. I understand that as with any surgical procedure there are possible complications including post-operative pain, bleeding, infection, temporary bruising or swelling of the face, allergic reaction to the medication, a change in sensation or numbness to the lip, chin, gum or tongue which is often temporary but can in rare situations be permanent. There is also the risk of an opening between the mouth and sinuses, injury or sensitivity to adjacent teeth, temporomandibular joint problems and poor healing.

4. I authorise Dr Oteng-Boateng to use his best judgement in managing unforeseen situations which may arise during the course of the procedure.

5. If a healthcare worker is directly exposed to my blood I agree to blood samples being taken. These samples will only be tested to identify such transmissible disease as are considered of significant risk to the worker e.g. hepatitis B and C, HIV. I understand that I will be informed of such testing and the results if I request them.

6. Do you want to keep your tissues/teeth? [] Yes [] No

Signature: _____ Date: _____