Dental Surgery Pre-Operative Medical Questionnaire

Full Name

Date of Birth

Contact Number

Email Address

Name of General Practitioner

Have you ever had or do you currently have any of the following? (Tick all that apply):

- [ ] Heart troubles
- [ ] Diabetes
- [ ] Asthma
- [ ] High/Low Blood Pressure
- [ ] Bleeding disorders
- [ ] Allergies
- [ ] Other

List all medications you are currently taking

Any known allergies (medications, materials, etc.)

Previous surgeries or hospitalizations (please specify)

Any history of unusual bleeding or bruising

Are you pregnant or breastfeeding?

Do you smoke?

Do you consume alcohol?

Any specific concerns or relevant medical history?

Signature

Date