



CAUSEWAY

dental

medical history

A. ARE YOU

1. Attending or receiving any treatment from your doctor, hospital, clinic or specialist? YES / NO
2. Taking any medicines or tablets prescribed by your doctor? YES / NO
3. Allergic to penicillin or any other drug or substance or foods (eg latex/rubber)? YES / NO
4. Pregnant or likely to be so? YES / NO

B. IN THE PAST HAVE YOU

1. Ever had a heart problem, angina, high or low blood pressure, heart attack or stroke? YES / NO
2. Ever had rheumatic fever? YES / NO
3. Ever had jaundice, hepatitis, liver problems or kidney disease? YES / NO
4. Ever had asthma, bronchitis, hayfever or any serious chest infections? YES / NO
5. Ever had any blood related diseases? YES / NO
6. Ever had a bad reaction to a local or general anaesthetic? YES / NO
7. Ever had an operation or received hospital treatment? YES / NO
8. Ever had a heart valve replaced? YES / NO
9. Had a blood transfusion from the Blood Transfusion Service? YES / NO
10. Had growth hormone treatment before the mid 1980's? YES / NO

C. DO YOU

1. Have a pacemaker? YES / NO
2. Have fainting attacks, giddiness or epilepsy? YES / NO
3. Have diabetes? YES / NO
4. Carry a warning card? YES / NO
5. Bruise easily or have you ever bled excessively? YES / NO
6. Take or have you ever taken steroids? YES / NO
7. Do you smoke? Typically how many per day? YES / NO
8. Have a close relative (parent, sibling, grandparent or grandchild) with Creutzfeldt Jakob disease? YES / NO
9. Drink alcohol (A unit is half a lager, a single measure spirit or glass of wine? YES / NO How many units per week?
10. Suffer from headaches or migraine? YES / NO
11. Suffer from Arthritis? YES / NO
12. Have any infectious diseases such as HIV, CJD or Hepatitis, if so what? YES / NO

