Medical History Questionnaire

Urban Dental Clinic | KN 2 St, TCB Building, Kigali | +250 788 200 723

General health

Are you currently under medical care? Yes / No

Reason: _____

Are you pregnant or breastfeeding? Yes / No / N.A.

Conditions (tick all that apply)

Diabetes Heart disease High blood pressure Asthma

Epilepsy Hepatitis HIV Bleeding disorder Other: _____

Medication & allergies

Current medication: _____

Allergies (incl. anaesthetic, latex, penicillin): _____

Declaration

I confirm the information above is accurate.

Signature: _____ Date: ____ / ____ / _____

Sample form — final version will be provided by the clinic.