

Patient Questionnaire (Confidential)



This questionnaire provides the information your dentist needs for your dental treatment and oral health care.

Preferred Title: MR / MRS / MISS / MS DR / PROF	(surname)	(first names)	
Address			
Email Address(es)			
Telephone	(home)	(work)	(mobile)
Date of birth	Occupation		
When did you last visit a dentist?	Name of your last dentist		
How did you hear of this practice?			
If you are under 16, please give name and address of parent/guardian			
Do you have dental insurance cover?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Name of your doctor/GP			
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you prefer:	<input type="checkbox"/> Amalgam (silver) fillings <input type="checkbox"/> Composite (white, non-metal) fillings, if suitable <input type="checkbox"/> No preference, guided by dentist <input type="checkbox"/> I wish to discuss this with the dentist		
<p>Although rare, accidental injury to staff can occur during handling of used instruments. If this happens during the course of your treatment, our practice requires both patient and staff member to undertake a blood test. Do you agree to a confidential blood test?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I wish to discuss this with the dentist			

Please complete the health questionnaire on the other side of this page.

In order to provide the best and safest dental treatment, your dentist needs to know of any medical problems which may affect your treatment.

Have you ever had any of the following (please tick Yes or No):	Cardiovascular:	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Open heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Respiratory:	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Chest & lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Sinus/hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Other:	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Gastric problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Depressive illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		Radiotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking any tablets, medicines, pills or drugs? If yes, please list.				
Have you ever had any allergies to medicines, or other substances (such as Latex)? If so, please list.				
Do you have an artificial or prosthetic joint?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever experienced excessive bleeding or bruising from dental treatment, or at any other time?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had contact with:	HIV virus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Hepatitis B virus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Hepatitis C virus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had an unfavourable reaction to an anaesthetic?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Women: Are you pregnant now? If so, how many weeks?				
Are there any other health matters you need to talk to the dentist about?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

I confirm that the information written above is true and correct to the best of my knowledge.

Signed by: Patient/Parent/Guardian _____ Date: _____

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