

Patient Questionnaire

(Confidential)

This questionnaire provides the information your dentist

needs for your dental treatment and oral health care.



**(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?** |  |
| Name of your doctor/GP |  |
| Do you smoke? |  |
| Do you prefer: | O Composite (white, non-metal) fillings, if suitable  O No preference, guided by dentist  O I wish to discuss this with the dentist |

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?

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: | Heart Murmur |  | |  |  |
|  | Rheumatic Fever |  | |  |  |
|  | Open heart surgery |  | |  |  |
|  | High blood pressure |  | |  |  |
|  | Stroke |  | |  |  |
|  | Asthma |  | |  |  |
|  | Chest & lung disease |  | |  |  |
|  | Sinus/hay fever |  | |  |  |
|  | Epilepsy |  | |  |  |
|  | Diabetes |  | |  |  |
|  | Kidney problems |  | |  |  |
|  | Gastric problems |  | |  |  |
|  | Depressive illness  Radiotherapy |  | |  |  |
| 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? | |  |  |  |  |
| Have you ever experienced excessive bleeding or bruising from | |  | |  |  |
| dental treatment, or at any other time? | |  | |  |  |
| HIV virus | |  | |  |  |
| Have you ever had contact with: Hepatitis B virus | |  | |  |  |
| Hepatitis C virus | |  | |  |  |