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CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care. It must be reconsidered and signed for every year.

Name: ____ (Surname) _____ (First Names) _____ (Dr / Mr / Mrs / Miss / Ms) _____

Home Address: _____

Home phone: _____
Mobile phone: _____
Work Phone: _____

Occupation: _____

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

MEDICAL HISTORY

Medical Doctors Name _____ Phone (If known) _____

1. Are you receiving any medical treatment at the present time? Or have you received treatment within the last two years? (including any stays in hospital)

Details: _____

2. Have you taken any medicine, tablets, capsules or drugs during the past two years?(other than paracetamol etc)

Details: _____ Yes / No

3. Have you experienced any ALLERGIES or unusual effects from any tablets, drugs, injections or anaesthetic?

Details: _____

4. Have you ever had any of the following? If so, please tick as appropriate.

Rheumatic Fever	Epilepsy
Heart Trouble	Anaemia
High Blood Pressure	Diabetes
Asthma	Kidney Trouble
Arthritis	Gastric Problems
Hepatitis - Specify type A, B, C	Cold Sores
Bronchitis or Chest Problems	Depressive Illness
Severe Headaches	Drug Dependence

5. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No

Details:

6. Women, Are you pregnant? If so, when is your expected due date Yes / No

7. Are you a carrier of any blood-borne viruses? Including HIV/Hep B Yes / No

Details

8. Are you at risk to HIV exposure? Yes / No

9. Do you smoke/ If so, how many per day? Yes/ No

10. How many units of alcohol do you drink per week? More than 15 [] Less than 15 []

DENTAL HISTORY

1. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No

2. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

PLEASE LIST ANY MEDICATION YOU ARE TAKING ON THE REVERSE OF THIS QUESTIONNAIRE.

Signed: Patient/Parent/Guardian _____ Date: _____