Confidential Patient Questionnaire

This provides the Dentist with important information required for your Dental treatment and Oral Health Care.

Name (Title) ____

Home Address: ____

Date of Birth: ____________________ E-mail____________________

Home Phone: ____________ Mobile:____________ Work:____________

Details of person to contact in an emergency

Name: ______________________________ Phone Number____________

Medical History

Are you receiving any medical treatment at present time? Yes/No

Details: ____

Have you been a patient in hospital during the past two years? Yes/No

Details: ____

Have you taken any medicine tablets, capsules or drugs during the past two years? Yes/No

Details: ____

Any allergies or unusual effects from tablets, antibiotics, injections or anaesthetic? Yes/No

Details: ____

Are you or have you been under the care of a GP/Consultant during the past three years? Yes/No

Details: ____

Have you had any of the following? If so, please tick as appropriate:

Rheumatic fever	Heart trouble	High blood pressure	Asthma
Arthritis	Hepatitis A, B, C	Bronchitis/chest problems	
Headaches/migraines	Anaemia	Diabetes	Cold sore
Kidney trouble	Gastric problems	Depression	Drug use

Have you had any prosthetic surgery? (eg. Heart valve or hip replacement)____________________

Women, are you pregnant? Yes/No If so how many months:____ Do you bleed excessively? Yes/No

Do you smoke? Yes/No How many? ____________ Weekly alcohol Intake ____________

Signature____

Date________________________