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# Confidential Patient Questionnaire

This provides the dentist with important information required for your dental treatment as well as your oral health care

## Patient Details:-

Prefix: First Name: Last Name:

D.O.B:

Home Address:

Post Code:

Telephone Number:

E-mail:

Occupation:

## Emergency Contact Details:-

Name: Relationship:

Telephone Number:

## GP Details:-

GP Practice Address:

Would you like us to contact your GP if we have any worries about your health?

## General:-

How did you locate the practice:

Passing by ✔ Word of mouth ✔ Leaflet ✔ Google ✔ Other ✔ Search Engine ✔ Friend/Relative registered ✔

## Dental History:

1. Name of your last dentist:
2. Approximate date of last dental visit:
3. Are you in any dental pain or have a dental problem at this moment?
4. Have you ever experienced excessive bleeding/bruising from dental treatment or from any cuts/scratches?
5. Do you become anxious/uncomfortable when you are having dental treatment?

**PTO**

# Confidential Patient Questionnaire
## Continued

### Medical History:-

1. Are you receiving any medical treatment at this present time?
2. Have you been admitted in hospital during the past 2 years?
   Details:
3. Have you taken any medicine tablets/capsules or drugs in the past 2 years?
   Details:
4. Have you experienced any allergies or unusual effects from any tablets/ drugs/medications/ injections or anaesthetic?
   Details:
5. Have you ever had any of the following:

| | |
|---|---|
| Rheumatic Fever: | Epilepsy: |
| Heart Trouble: | Anaemia: |
| High Blood Pressure: | Diabetes: |
| Asthma: | Kidney Trouble: |
| Arthritis: | Gastric Problem: |
| Hepatitis - Type: | Cold Sores: |
| Bronchitis/Chest Problem: | Depressive Illness: |
| Severe Headaches: | Drug dependence: |

6. Have you ever had any prosthetic surgery? (Heart Valve/Hip Replacement)
   Details:
7. Do you take any blood thinners/Bisphosphonates?
8. If you are a woman, are you pregnant?
9. Do you vape? Smoke? How many a day?
10. Do you drink alcohol? How many units a week?
11. Do you snore or have sleep apnoea?

### Sign:

Patient : ✔ Parent/Guardian: ✔ Signature:

Date:

Dentist: Date: