Confidential Patient Questionnaire - Great Junction Dental Practice

This provides the dentist with important information required for your Dental Treatment and Oral Health Care

Dr/Mr/Master/Mrs/Miss/Ms ……, ……..... Date of Birth……/……/…….
(Surname) (First Names)

Home Address…….....

…….....Postcode……...

Home phone…….....Work Phone……

Mobile phone…….....Occupation…….

Email…….....Fax…….....

General Practitioner…….....Phone Number……

Details of person to contact in an emergency:

Name…….Relationship……Phone…….

Medical History (please circle as appropriate)

1. Are you receiving any medical treatment at the present time?
Details……..... Yes/No
2. Have you been a patient in hospital during the last two years?
Details……..... Yes/No
3. Have you taken/are you taking any medicine, tablets, capsules or drugs during the last two years?
Details……..... Yes/No
4. Have you had allergies/unusual effects from any tablets, drugs, injections or anaesthetics?
Details……..... Yes/No
5. Are you, or have you been under the care of a doctor during the past two years?
Details……..... Yes/No

6. Are you a smoker? Yes/No

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

Rheumatic fever/Chorea	Diabetes	Heart Trouble
High Blood Pressure	Bronchitis	Anaemia
Asthma	Depressive Illness	Severe Headaches
Multiple Sclerosis	Epilepsy	Drug Dependence
Hepatitis (specify Type A, B, C)		Gastric Problems

8. Have you ever had prosthetic surgery? E.g. Heart valve or Hip replacement
Details……..... Yes/No

9. WOMEN: Are you pregnant? Yes/No

10. Are you HIV positive or at risk to HIV exposure? Yes/No

Dental History

Name of last dentist approximate date of last dental visit

Have you had excessive bleeding or bruising from dental treatment?

Signed: Patient/Parent/Guardian **Date**