



## CONFIDENTIAL PATIENT QUESTIONNAIRE

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

Miss/Ms/Mrs/Mst/Mr

NHS number

**Surname**

**First Name**

**Date Of Birth**

Home Address \_\_\_\_\_ Work Address: \_\_\_\_\_

Post Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobil Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Email address;** \_\_\_\_\_

### Details of person to contact in an emergency:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Medical Doctors Name: \_\_\_\_\_ Phone (If known): \_\_\_\_\_

### MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No  
Details: \_\_\_\_\_
2. Have you been a patient in hospital during the past two years? Yes / No  
Reason: \_\_\_\_\_
3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No  
Details: \_\_\_\_\_
4. Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Yes / No  
Details: \_\_\_\_\_
5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No  
Reason: \_\_\_\_\_
6. Have you ever had any of the following? If so, please tick as appropriate.
 

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Anaemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastric Problems
<input type="checkbox"/> Hepatitis - Specify type A, B, C	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Bronchitis or Chest Problems	<input type="checkbox"/> Depressive Illness
<input type="checkbox"/> Severe Headaches	<input type="checkbox"/> Drug Dependence
7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No  
Details: \_\_\_\_\_
8. Woman, Are you pregnant? If so, how many months: \_\_\_\_\_ Yes / No
9. Are you HIV positive? Yes / No
10. Are you at risk to HIV exposure? Yes / No

### DENTAL HISTORY

1. Name of Last Dentist: \_\_\_\_\_
2. Approximate date of last dental visit:  
Details: \_\_\_\_\_
3. Do you have Dental pain or a Dental problem at present? Yes / No  
Details: \_\_\_\_\_
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No
6. Do you smoke or chew tobacco? How many a day? Yes / No
7. Do you drink alcohol how many unit(s) a week? Yes / No

### Referred By:

- Yellow Pages  Another patient/friend (Name) \_\_\_\_\_  
 Street Sign  Other (Please specify) \_\_\_\_\_

Our cancellation policy for Dentist is appointment is 48 hours  
and Hygienist is 72 hrs notices. Otherwise there is a penalty  
charge for non-attendance

I have read the NHS new patient form \_\_\_\_\_

Signed: Patient/Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_