This confidential questionare provides the information your dentist needs for your dental treatment and oral care.

Patient Health **Questionare**

PREFERRED TITLE: Mr Mrs Miss Ms

SURNAME

FIRST NAMES

ADDRESS:

EMAIL:

TELEPHONE:

Home

Mobile

PREFERRED CONTACT: Email Text Phone Mail

DATE OF BIRTH:

OCCUPATION:

WHEN DID YOU LAST VISIT A DENTIST?

NAME OF YOUR LAST DENTIST?

HOW DID YOU HEAR OF THIS PRACTICE?

IF YOU ARE UNDER 16, PLEASE GIVE NAME AND ADDRESS OF PARENT/GUARDIAN

DO YOU HAVE DENTAL INSURANCE COVER? Yes No

NAME OF YOUR DOCTOR/GP:

DO YOU SMOKE? Yes No

DO YOU PREFER:

Amalgam (silver) fillings

Composite (white, non-metal) fillings, if suitable

No preference, guided by dentist

Allthough rare, accidental injury to staff can occur during handling of used instruments. If this happens during the course of your treatment, our practice requires both patient and staff member to undertake a blood test. Do you agree to a confidential blood test?

Yes No I wish to discuss this with the dentist

Questionare: In order to provide the best and safest dental treatment, your dentist needs to know of any medical problems which may affect your treatment.

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please tick if applicable)

Cardiovascular:	Stroke	Heart Attack	Open Heart Surgery	High Blood Pressure
	Heart Murmur	Rheumatic Fever		
Respiratory:	Asthma	Chest & Lung Disease	Sinus/Hay Fever	
Other:	Epilepsy	Diabetes	Kidney Problems	Gastric Problems
	Depressive Illness	Radiotherapy/ Chemotherapy		

ARE YOU TAKING ANY TABLETS, MEDICINES, PILLS OR DRUGS? If yes, please list.

HAVE YOU EVER HAD ANY ALLERGIES TO MEDICINES, OR OTHER SUBSTANCES (SUCH AS LATEX)? If SO, please list.

DO YOU HAVE AN ARTIFICIAL OR PROSTHETIC JOINT?		Yes	No
HAVE YOU EVER EXPERIENCED EXCESSIVE BLEEDING OR BRUISING FROM DENTAL TREATMENT, OR AT ANY OTHER TIME?		Yes	No
HAVE YOU EVER HAD CONTACT WITH:	HIV Virus	Yes	No
	Hepatitus B Virus	Yes	No
	Hepatitus C Virus	Yes	No
HAVE YOU EVER HAD AN UNFAVOURABLE REACTION TO ANAESTHETIC?		Yes	No

WOMEN: ARE YOU PREGNANT NOW? If so how many weeks?

ARE THERE ANY OTHER HEALTH MATTERS YOU NEED TO TALK TO THE DENTIST ABOUT?	Yes	No

I CONFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signed by: Patient/Parent/Guardian Date:

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