Confidential Patient Questionnaire

This provides the dentist with important information required for your dental treatment and oral health care.

Corfe Mullen
Dental Surgery

PATIENT HISTORY

Patient's Title ______ Surname ______

First names ______

Date of birth ______

Occupation ______

Are you the patient, parent, guardian or carer? ______

If you are completing this form on behalf of someone else, do they have:

Special needs Yes ○ No ○

Learning difficulties Yes ○ No ○

Any form of dementia Yes ○ No ○

Have your contact details changed? Yes ○ No ○

If yes please fill in new contact details below.

Address ______

Postcode ______

Home Tel ______ Work Tel ______

Mobile ______

Email ______

Are happy for us to call/leave messages/send text reminders on your home/work/mobile telephone? Yes ○ No ○

Details of person to contact in an emergency

Name ______

Tel ______

Doctor's name ______

Doctor's surgery address ______

Doctor's tel ______

Are you exempt from NHS dental charges? Yes ○ No ○

DENTAL HISTORY

1. Name of last dentist ______

2. Date of last dentist visit ______

3. Do you have dental pain or a health problem at present that the dentist may need to know about? Yes ○ No ○

Details ______

4. Have you been seen by a hygienist before? Yes ○ No ○

5. Do you smoke? Yes ○ No ○

How many cigarettes per day? ______

How many years have you smoked? ______

6. Have you ever smoked? Yes ○ No ○

7. How many units of alcohol do you drink in a week?

0 ○ 1-10 ○ 11-20 ○ 20+ ○

8. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes ○ No ○

9. Do you become anxious or uncomfortable when you are having dental treatment? Yes ○ No ○

10. Do you ever suffer from a dry mouth? Yes ○ No ○

11. Have any members of your family suffered from gum disease? Yes ○ No ○

12. Do you use a fluoride toothpaste? Yes ○ No ○

13. Do you have a high fruit/fruit juice intake? Yes ○ No ○

14. Do you take sugar in tea or coffee? Yes ○ No ○

Questionnaire continued overleaf...

BDA goodpractice

Confidential Patient Questionnaire continued....

MEDICAL HISTORY

1. Have you been a patient in hospital or under care of a doctor during the past two years? Yes No

Reason

2. Are you taking any prescribed medicine tablets, capsules, drugs or homeopathic remedies? (e.g. Contraceptive pill, inhalers, hormone replacement therapy, blood pressure tablets)

Yes No

Details

3. Are you carrying a medical card? Yes No

If so, what is the card for?

4. Have you ever taken Biphosphonates? (Used in certain cancer treatments and osteoporosis). Yes No

5. Have you experienced any allergies or unusual effects from tablets, drugs, injections or anaesthetic? Yes No

Details

6. Do you have any allergies eg. latex, rubber gloves?

Yes No

7. Have you ever had any of the following?

Please tick as appropriate

- Rheumatic fever
- Cancer
- High blood pressure
- Bronchitis or asthma
- Arthritis
- Depressive illness
- Epilepsy
- Heart trouble or angina
- Diabetes
- Kidney trouble
- Cold sores
- Drug dependence
- Hepatitis - specify type A, B, C
- Any infectious diseases including HIV

8. Have you had blood refused by the Blood Transfusion Service?

Yes No

9. Have you had a joint replacement? Yes No

10. Have you had a heart pacemaker or replacement valve?

Yes No

11. Are you pregnant? Yes No

12. Have you had brain surgery prior to 1992? Yes No

13. Have you had Growth Hormone Treatment before 1982?

Yes No

14. Have you got a blood relative with Familial Creutzfeldtn Jakob Disease? Yes No

Signed: Date:

Dentist signed: Date:

If you fail to attend your first appointment, unfortunately we will not be able to see you at the practice again.

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