## **Confidential Patient Questionnaire**

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



PATIENT HISTORY	DENTAL HISTORY
Patient's Title Surname	1. Name of last dentist
First names	2. Date of last dentist visit
Date of birth	<b>3.</b> Do you have dental pain or a health problem at present that
Occupation	the dentist may need to know about? Yes No
Are you the patient, parent, guardian or carer?	Details
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	<b>4.</b> Have you been seen by a hygienist before? Yes No
If <b>yes</b> please fill in new contact details below.	
Address	5. Do you smoke? Yes No
	How many cigarettes per day?
Postcode	How many years have you smoked?
Home Tel Work Tel Mobile	6. Have you ever smoked? Yes No
Email	7. How many units of alcohol do you drink in a week?
	0 1-10 11-20 20+
Are happy for us to call/leave messages/send text reminders on your home/work/mobile telephone? Yes No	8. Have you ever experienced excessive bleeding or bruising
	from dental treatment, cuts or scratches? Yes No
Details of person to contact in an emergency Name	9. Do you become anxious or uncomfortable when you are
Tel	having dental treatment? Yes No
Doctor's name	<b>10.</b> Do you ever suffer from a dry mouth? Yes No
Doctor's surgery address	<b>11.</b> Have any members of your family suffered from gum disease? Yes No
	<b>12.</b> Do you use a fluoride toothpaste? Yes No
Doctor's tel	<b>13.</b> Do you have a high fruit/fruit juice intake? Yes No
	<b>14.</b> Do you take sugar in tea or coffee? Yes No
Are you exempt from NHS dental charges? Yes 🔍 No 🔍	Quantiannaira continuad quarlaaf
	Questionnaire continued overleaf



## **Confidential Patient Questionnaire continued....**

Yes

No

No

## **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)

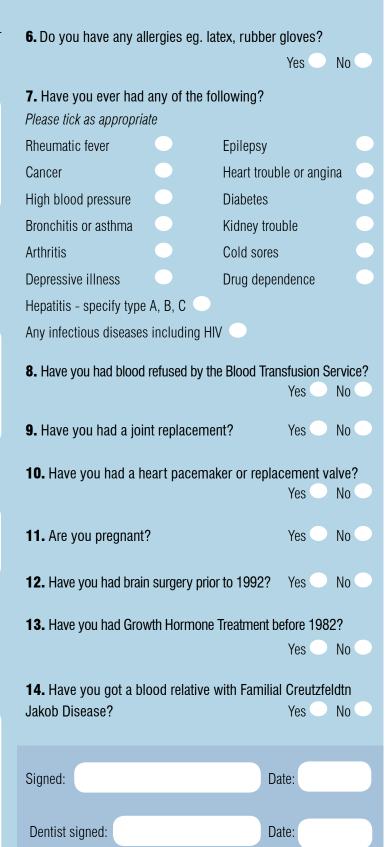
Details

 3. Are you carrying a medical card?
 Yes

 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



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

