

Confidential Patient Questionnaire

Patient details

First name	Middle name	Surname
Date of birth	School or Occupation	Phone
Postal address		Mobile
		Email

How did you hear about us? Dentist, friend, website, advert, google

When did you last visit a dentist?

Are you taking any tablets, medicines, pills or drugs? If yes, please list:

Name of your last dentist

Have you ever had an allergic reaction to medicines, or other substances such as latex? If yes, please list:

Have you ever had any of the following?

- | | | |
|---|--|--|
| <input type="radio"/> Heart murmur | <input type="radio"/> Asthma | <input type="radio"/> Kidney problems |
| <input type="radio"/> Rheumatic fever | <input type="radio"/> Chest and lung disease | <input type="radio"/> Gastric problems |
| <input type="radio"/> Open heart surgery | <input type="radio"/> Sinus/Hay fever | <input type="radio"/> Depressive illness |
| <input type="radio"/> High blood pressure | <input type="radio"/> Epilepsy | <input type="radio"/> Radiotherapy |
| <input type="radio"/> Stroke | <input type="radio"/> Diabetes | |

Have you ever had contact with:

Yes/No

- | | |
|---|---|
| <input type="radio"/> HIV virus | <input type="radio"/> Do you have an artificial or prosthetic joint? |
| <input type="radio"/> Hepatitis B virus | <input type="radio"/> Have you ever experienced excessive bleeding or bruising from dental treatment, or at any other time? |
| <input type="radio"/> Hepatitis C virus | <input type="radio"/> Have you ever had an allergic reaction to an anesthetic? |
| | <input type="radio"/> Women: Are you pregnant? If so, how many weeks? _____ |
| | <input type="radio"/> Do you smoke? |

Account holder details (must be over 18 years)

Mr/Mrs/Miss/Ms/Dr/Prof	First name	Surname
Relationship to patient		Phone
Address		Mobile
		Email

Please sign below

Signed by patient	Date
Signed by parent/guardian	Date