The Dental Centre

Working for your smile

1210 London Road
Norbury
London SW16 4DN

CONFIDENTIAL PATIENT QUESTIONNAIRE *(Additional space for details overleaf, if required)*

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

Name: ____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Home Address: ____________________ Mobile Phone: ____________________
____________________ Other Phone: ____________________
____________________ Work Phone: ____________________
E-mail address: ____________________ Date of Birth: ____________________
Occupation: ____________________

Details of person to contact in an emergency:

Name: ____________________ Phone Number: ____________________

MEDICAL HISTORY

1. Medical Doctors Name / Practice Name: ____________________ Phone (If known): __________
2. Are you receiving any medical treatment at the present time? Yes / No
   Details: ____________________
3. Have you been a patient in hospital during the past two years? Yes / No
   Reason: ____________________
4. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No
   Details: ____________________
5. Have you experienced any allergies or unusual effects from any tablets,drugs,injections or anaesthetic? Yes / No
   Details: ____________________
6. Are you, or have you been, under the care of a doctor during the past two years? Yes / No
   Reason: ____________________
7. Have you ever had any of the following? If so, please tick as appropriate.
   - ☐ Rheumatic Fever / Heart Valve Defect
   - ☐ Heart Trouble
   - ☐ High Blood Pressure
   - ☐ Asthma
   - ☐ Arthritis
   - ☐ Hepatitis - Specify type A, B, C
   - ☐ Bronchitis or Chest Problems
   - ☐ Severe Headaches
   - ☐ Epilepsy
   - ☐ Anaemia
   - ☐ Diabetes
   - ☐ Kidney Trouble
   - ☐ Gastric Problems
   - ☐ Cold Sores
   - ☐ Depressive Illness
   - ☐ Drug Dependence
8. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No
   Details: ____________________
9. Woman, Are you pregnant? If so, how many months: __________ Yes / No
10. Are you HIV positive? Yes / No
11. Are you at risk to HIV exposure? Yes / No
12. Have you or anyone in the family history of CJD Yes / No
13. Do you smoke or chew tobacco or eat Paan/Supari (Betel nut) Yes / No
14. Alcohol Consumption: __________ units per week

DENTAL HISTORY **(This section not necessary if you have attended this practice in the last 2 years)**

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. How often do you (please circle) **brush** your teeth daily/twice daily/occasionally **floss** never/occasionally/daily

Referred By:

- ☐ Yellow Pages
- ☐ Street Sign
- ☐ Another patient/friend /dentist (Name)__________
- ☐ Other (Please specify, e.g. website) __________

Signed: Patient/Parent/Guardian ____________________ Date: __________

Updated (initial dentist/date):__________ __________ __________ __________ __________

Details:

MEDICAL HISTORY