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	☐ Epilepsy
☐ Heart Trouble	☐ Anaemia
☐ High Blood Pressure	☐ Diabetes
☐ Asthma	☐ Kidney Trouble
☐ Arthritis	☐ Gastric Problems
☐ Hepatitis - Specify type A, B, C	☐ Cold Sores
☐ Bronchitis or Chest Problems	☐ Depressive Illness
☐ Severe Headaches	☐ 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	☐ Another patient/friend /dentist (Name)_____
☐ Street Sign	☐ Other (Please specify, e.g. website) _____

Signed: Patient/Parent/Guardian _____ Date: _____

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

Details:

MEDICAL HISTORY