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## CONFIDENTIAL PATIENT QUESTIONNAIRE

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
D.O.B: _____		
Home Address: _____	Work Address: _____	
_____	_____	
_____	_____	
Home Phone: _____	Work Phone: _____	
Email Address _____	Mobile: _____	
Occupation: _____		
Emergency contact: _____ (Please specify)		

Medical Doctors Name & Address: \_\_\_\_\_  
Phone (If known): \_\_\_\_\_

### MEDICAL HISTORY

- Are you receiving any medical treatment at the present time? Yes / No  
Details: \_\_\_\_\_
- Have you been a patient in hospital during the past two years? Yes / No  
Reason: \_\_\_\_\_
- Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No  
Details: \_\_\_\_\_
- Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Yes / No  
Details: \_\_\_\_\_
- Are you, or have you been, under the care of a doctor during the past two years? Yes / No  
Reason: \_\_\_\_\_
- Have you ever had any of the following? If so, please tick as appropriate.

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Anaemia
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastric Problems
<input type="checkbox"/> Hepatitis - Specify type A, B, C	<input type="checkbox"/> Cold Sores
<input type="checkbox"/> Bronchitis or Chest Problems	<input type="checkbox"/> Depressive Illness
<input type="checkbox"/> Severe Headaches	<input type="checkbox"/> Drug Dependence
- Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No  
Details: \_\_\_\_\_
- Woman, Are you pregnant? If so, how many months: \_\_\_\_\_ Yes / No
- Are you HIV positive? Yes / No
- Are you at risk to HIV exposure? Yes / No

### DENTAL HISTORY

- Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
- Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

**SOCIAL HISTORY**

1. Number of units of alcohol per week: \_\_\_\_\_

2. Do you smoke? Yes/No Past: \_\_\_\_\_ per day Present: \_\_\_\_\_ per day

**Signed:** Patient/Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_