

Warwick's Dental Health
CONFIDENTIAL PATIENT QUESTIONNAIRE

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

MEDICAL HEALTH HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No

Details:

2. Are you allergic to anything e.g. penicillin, latex etc? Yes / No

Details:

3. Are you taking any medicine tablets, capsules or drugs or injections? Yes / No

Details:

4. Any other relevant medical health issues?

Details:

5. Have you ever had any of the following?

Please circle and give details

- | | | | |
|-----|----|-----------------------------------------------|-------|
| Yes | No | Rheumatic Fever, chorea, St Vitas dance | |
| Yes | No | Heart Valve or Hip Replacement | <hr/> |
| Yes | No | High Blood Pressure | <hr/> |
| Yes | No | Heart Trouble | <hr/> |
| Yes | No | Asthma, Bronchitis or Chest Problems | <hr/> |
| Yes | No | Severe bleeding after surgery or extractions? | <hr/> |
| Yes | No | Diabetes | <hr/> |
| Yes | No | Epilepsy | <hr/> |
| Yes | No | Liver disease, hepatitis, or jaundice | <hr/> |
| Yes | No | Kidney Trouble or Gastric Problems | <hr/> |
| Yes | No | HIV or CJD | <hr/> |
| Yes | No | Currently pregnant or nursing a baby | <hr/> |

Medical Doctors Name:

Medical Doctors Address/Practice:

Postcode

Phone No (If known):

Signed:
Patient/Parent/Guardian

Date:

First Name:	Surname:	Title:	Date of Birth:
Home Address:		Home Phone:	
		Home Email:	
		Work Phone:	
		Work Email:	
		Mobile Phone:	
Postcode:			

Preferred contact method:

Home Phone Home Email Work Phone Work Email Mobile Phone

Is it OK to leave a message stating who we are? Yes / No

SOCIAL HISTORY

1. Occupation:

2. Do you smoke? Yes /No

Given up for _____ years / months

No. per day? _____.

How many years? _____.

3. Do you drink alcohol? Yes / No

Drinks per week? _____.

4. How stressed are you?

(Please indicate for the last 6 months)

Not at all 1 2 3 4 5 6 7 8 9 10 Very

DENTAL HISTORY

1. How long since your last dental visit?:

2. Are you anxious about dental treatment?

Yes / No

How anxious are you?

Not at all 1 2 3 4 5 6 7 8 9 10 Very

2. Particular things that make you anxious?

2. Are you happy with the appearance of your teeth?

yes / no / could be improved

Please specify:

5. Anything else we need to know about?

How did you find out about us?

Advert Another patient/friend Street Sign Referring dentist

Other (Please specify)