



CONFIDENTIAL PATIENT QUESTIONNAIRE

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

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

Home Address: _____ Work Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____

Alternate Phone: _____ (Please specify)
(Mobile, Fax, Email, Next of Kin)

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ 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
- Do you smoke

DENTAL HISTORY

- Name of Last Dentist: _____
- Approximate date of last dental visit:
Details: _____
- Do you have Dental pain or a Dental problem at present? Yes / No
Details: _____
- 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

Referred By:

- Yellow Pages Another patient/friend (Name) _____
 Street Sign Other (Please specify) _____

Signed: Patient/Parent/Guardian _____ Date: _____