Patient Questionnaire

TITLE:			
FIRST NAME:			
SURNAME:			
DATE OF BIRTH:	**HOME TEL:** **MOBILE TEL:**		
HOME ADDRESS:			
POSTCODE:			
EMAIL:			
NHS NUMBER: **(Your NHS number can be requested from your GP, they may ask you for identification)**			
OCCUPATION :			
IF STUDENT SCHOOL/COLLEGE ATTENDING			
YOUR DOCTORS NAME:			
DOCTORS PRACTICE NAME:			
DOCTORS PRACTICE ADDRESS:			
POSTCODE:			
HOW DID YOU HEAR ABOUT THE PRACTICE?			
ONLINE		**WORD OF MOUTH**	
YELLOW PAGES		**WEBSITE**	
LEAFLET		**OTHER (Please specify)**	
WHO MAY WE THANK YOU FOR INTRODUCING YOU?			
SIGNATURE:		**DATE:**	

OPTIONAL QUESTIONS			
HOW OFTEN DO YOU BRUSH YOUR TEETH AND FOR HOW LONG?			
TWICE A DAY		ONCE A DAY	
WHEN I REMEMBER		MORE THAN TWICE A DAY	
HOW OFTEN DO YOU FLOSS OR USE OTHER INTER-DENTAL PRODUCTS?			
TWICE A DAY		ONCE A DAY	
WHEN I REMEMBER		MORE THAN TWICE A DAY	
WHEN BRUSHING YOUR TEETH DO YOU EVER HAVE ANY BLEEDING FROM THE GUMS?			**YES** **NO**
DO YOU HAVE ANY CURRENT CONCERNS WITH YOUR TEETH?			**YES** **NO**
WOULD YOU CONSIDER YOURSELF AS A NERVOUS DENTAL PATIENT?			**YES** **NO**
WHAT MAKES YOU NERVOUS?			
WHEN DID YOU LAST VISIT THE DENTIST?			
HAVE YOU EVER VISITED THE HYGENIST?			
IF YOU HAVE ANY CROWNS/BRIDGES/IMPLANTS OR DENTURE PLEASE LIST:			
ARE YOU HAPPY WITH YOUR SMILE?			**YES** **NO**
IF NOT WOULD YOU LIKE TO DISCUSS THE OPTIONS AVAILABLE TO YOU?			**YES** **NO**
WE OFFER TEETH WHITENING, IS THIS SOMETHING YOU WOULD LIKE TO DISCUSS?			**YES** **NO**
WE OFFER TEETH STRAIGHTENING, IS THIS SOMETHING YOU WOULD LIKE TO DISCUSS			**YES** **NO**
WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER AND OTHER PRACTICE UPDATES BY EMAIL?			**YES** **NO**

Medical History

Units of alcohol
1pint=3units, Wine 175ml = 2 unit, Alcopop 1.4 units, single spirit = 1 unit, Bottle wine = 10 units

HABITS			
	Qty		
Smoke (per day)		High sugar diet	Y/N
Chew Tobacco (per day)		Frequent fizzy drinks	Y/N
Alcohol Units (per week)		Recreational drugs	Y/N
Details			
HEART			
Rheumatic fever	Y/N	Heart Murmur	Y/N
High Blood Pressure	Y/N	Angina	Y/N
Heart surgery	Y/N	Thrombosis	Y/N
Pacemaker Fitted	Y/N	Other heart conditions	Y/N
Details			
BLOOD			
Hepatitis B	Y/N	Anaemia	Y/N
H.I.V	Y/N	Sickle cell	Y/N
Abnormal Blood Test	Y/N	Haemophilia	Y/N
Blood refused by transfusion service	Y/N	Other blood conditions	Y/N
Details			
ALLERGIES			
Penicillin	Y/N	Latex Allergy	Y/N
Hay Fever	Y/N	Medicines	Y/N
Anti Tetanus Serum	Y/N	Plants	Y/N
Eczema	Y/N	Foods	Y/N
General Anaesthetic	Y/N	Aspirin	Y/N
Local Anaesthetic	Y/N	Other Allergy Conditions	Y/N
Details			

WARNINGS			
Pregnant or possibly pregnant	Y/N	Do not Recline	Y/N
Antibiotic Cover Required	Y/N	Steroids within 2 years	Y/N
Bruising or persistent bleeding	Y/N	Warning card	Y/N
Currently under Treatment	Y/N	Treatment Req Hospitalisation	Y/N
Anything Dentist should know	Y/N		
Details			
CHEST			
Bronchitis	Y/N	Emphysema	Y/N
Cystic fibrosis	Y/N	Pneumonia	Y/N
Pleurisy	Y/N	Chest surgery	Y/N
Asthmatic	Y/N	Other chest conditions	Y/N
Details			
MEDICATION List			
OTHER			
Liver Disease	Y/N	Kidney disease	Y/N
Diabetes	Y/N	Epilepsy	Y/N
Acid Reflux or eating Disorder	Y/N	Hiatus Hernia	Y/N
Bone or joint disease	Y/N	Artificial joint	Y/N
Fainting attacks or blackouts	Y/N	Giddiness	Y/N
Past serious or infectious disease	Y/N	Cancer	Y/N
Details			

Signature: ..... Date: .....

Name: .....

DOB: .....