



Confidential Patient Questionnaire

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

Title: _____ First Name: _____ Surname: _____

Home Address: _____

Post Code: _____

Date of Birth: _____ E-mail: _____

Home Phone: _____ Mobile: _____

Occupation: _____

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical History

Are you receiving any medical treatment at present time? Details: _____

Have you been a patient in hospital during the past two years? Details: _____

Have you taken any medicine tablets, capsules or drugs during the past two years?

Details: _____

Any allergies or unusual effects from tablets/antibiotics/injections/anaesthetic? _____

Are you or have you been under the care of a GP/Consultant during the past three years? Details: _____

Have you had any of the following? If so, please tick as appropriate:

- | | |
|--|--|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis A, B, C, Type ___ |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Bronchitis/chest problems |
| <input type="checkbox"/> Previous | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anaemia |
| <input type="checkbox"/> Prone to fits/faints/blackouts | <input type="checkbox"/> Diabetes, Type ___ |
| <input type="checkbox"/> Allergies? Latex/ Penicillin etc, please specify: _____ | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> HIV positive (or at risk) | <input type="checkbox"/> Kidney trouble |
| <input type="checkbox"/> High / Low Blood Pressure, please specify: _____ | <input type="checkbox"/> Gastric problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug use |

Have you had any prosthetic surgery? (eg. Heart valve or hip replacement) _____

Women, are you pregnant? Yes/No, if so how many months: _____

Do you bleed excessively? Yes/No

Do you smoke? Yes/No how many? _____ Weekly alcohol Intake _____

Please be aware that our dental chairs have a maximum weight limit of 135kg (21st). If you think you exceed this limit, please inform the dentist.

I consent to Lechlade Dental Practice calling/leaving an answer phone message or message with a family member with the details of my dental appointment time and date. I am also aware that there is a late cancellation charge applied if I fail to give less than 24 hours' notice to cancel my appointment.

Signature: _____ Date: _____