St John's Dental Practice

Advanced Dental Care

Confidential Patient Questionnaire

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

Personal Details:

Title: _____ First Name: _____ Surname: _____

Date of Birth: _____

Home Address: _____

_____ Post Code: _____

E-mail: _____

Home Phone: _____ Mobile: _____

Preferred Method of Contact: _____

Occupation: _____

Details of person to contact in an emergency:

Name: _____

Phone Number: _____ Relation: _____

Your GP Details: _____

_____

Medical History:

Have you had any of the following? If so, please tick as appropriate and provide details where possible:

- ☐ Heart condition (angina, heart attack, etc) please specify:
- ☐ Rheumatic fever
- ☐ Epilepsy
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Prone to fits/faints/blackout
- ☐ Allergies (please specify):
- ☐ HIV positive (or at risk)
- ☐ High/Low blood pressure (please specify High or Low):
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis A, B, C (please specify Type)
- ☐ Blood refused by Blood Tranfusion Service
- ☐ Bronchitis / Chest problems
- ☐ Diabetes (please specify Type)
- ☐ Kidney trouble
- ☐ Gastric Problems
- ☐ Depressive illness
- ☐ Drug use / dependence
- ☐ Cold sores
- ☐ Headaches / Migraines

PTO

- Sleep disturbance from clenching teeth or snoring (please specify):

Are you receiving any medical treatment at present time from GP/hospital/specialist?

_____

_____

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

_____

_____

Taking any medication prescribed by your doctor (tablets, creams, injections, other)?

_____

_____

Any **allergies** or unusual effects from food/tablets/antibiotics/anaesthetic/other?

_____

_____

Have you had any prosthetic surgery? (e.g. Heart Valve or Hip Replacement)?

_____

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

Do you bleed excessively? Yes / No Weight: _____

Social History:
Do you smoke? Yes / No
If yes, how many per day? _____

Estimated weekly alcohol intake? _____
(Pint = 2 Units, Bottle of Wine = 9 Units, Glass of Wine = 1 or 2 units, Can of beer/Lager/Cider = 2 Units)

How did you hear about us? _____

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.

By signing this form, you are consenting to St Johns Dental Practice calling/leaving an answer phone message or message with a family member with the details of your dental appointment time and date. You also consent to photography where required; to be uploaded to your personal file as part of clinical recordkeeping only.

Please be aware that a late cancellation charge will be applied if you fail to give more than 48 hours' notice to cancel your appointment.

Patient Signature: _____ **Date:** _____

Reviewed by Dentist
Signature: _____ **Date:** _____