Aycliffe Dentistry

CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care which is treated as confidential and won't be given to a 3rd party without your consent.

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

D.O.B: _____ NHS Number. _____

Home Address:_____ Email Address: _____

_____

_____

Home Phone: _____ Work Phone: _____

Occupation: _____

Details of person to contact in an emergency:

Name:_____Phone Number: _____

Doctors Name_____Phone _____

Address._____

I give permission to be contacted regarding appointment reminders via text/email. Yes/No
I give permission to be contacted with important notifications and newsletters Yes/No

MEDICAL HISTORY

1. Are you receiving any medical treatment at the present time? Yes / No
   Details: _____
2. Have you been a patient in hospital or under the care of a doctor during the past two years? Yes / No
   Reason: _____
3. Have you taken any medicine tablets, drugs or injections or using creams, ointments or inhalers Yes / No
   Details: _____
4. Have you experienced any allergies or unusual effects from any materials, medications or anaesthetic? Yes / No
   Details: _____
5. List any self prescribed medicines e.g. Aspirin Yes / No
   Details: _____
6. Have you ever had any of the following? If so, please tick as appropriate.

o Rheumatic Fever	o Epilepsy	o Cold Sores
o Heart Trouble	o Anaemia	o Depressive Illness
o High Blood Pressure	o Diabetes	o Drug Dependence
o Asthma	o Kidney Trouble	o Hepatitis - Specify type A, B, C
o Arthritis	o Gastric Problems	o Bronchitis or Chest Problems

7. Have you had any prosthetic surgery? (E.g. Heart Valve or Hip Replacement) Yes / No
   Details: _____
8. Woman, Are you pregnant or breastfeeding? Yes / No
9. Are you HIV positive? Yes / No
10. Are you at risk to HIV exposure? Yes /No
11. Do you smoke or chew tobacco? If so, how many per day_____
12. Do you snore or suffer from sleep apnoea? Yes/No
13. Do you drink alcohol? If so how many units per week_____

DENTAL HISTORY

1. Approximate date of last dental visit:
2. Do you have Dental pain or a Dental problem at present? Yes / No
   Details: _____
3. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
4. Is there any other condition your dentist needs to be aware of that may affect your dental treatment? Yes / No
   Details: _____

Signed: Patient/Parent/Guardian_____Date:_____Dentist signature_____Date_____