

CONFIDENTIAL PATIENT QUESTIONNAIRE

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

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

1. Are you receiving any medical treatment at the present time? Yes / No
Details: _____
2. Have you been a patient in hospital during the past two years? Yes / No
Reason: _____
3. Have you taken any medicine tablets, capsules or drugs during the past two years? Yes / No
Details: _____
4. Have you experienced any allergies or unusual effects from any tablets, drugs, injections or anaesthetic? Yes / No
Details: _____
5. Are you, or have you been, under the care of a doctor during the past two years? Yes / No
Reason: _____
6. 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
7. Have you had any prosthetic surgery? (eg Heart Valve or Hip Replacement) Yes / No
Details: _____
8. Woman, Are you pregnant? If so, how many months: _____ Yes / No
9. Are you HIV positive? Yes / No
10. Are you at risk to HIV exposure? Yes / No

DENTAL HISTORY

1. Name of Last Dentist: _____
2. Approximate date of last dental visit:
Details: _____
3. Do you have Dental pain or a Dental problem at present? Yes / No
Details: _____
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Another patient/friend (Name) _____ |
| <input type="checkbox"/> Street Sign | <input type="checkbox"/> Other (Please specify) _____ |

Signed: Patient/Parent/Guardian _____

Date: _____