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Confidential Medical and Dental Questionnaire

To provide the best and safest treatment, your dentist needs to know of any health issues. Providing the following information also enables us to help you make informed decisions regarding your dental health. Please complete this questionnaire and bring it with you to your appointment.

Title	Mr / Mrs / Miss / Ms / Dr	Other	
Forename		Surname	
Address			
		Postcode	
Home tel		Date of Birth	
Work		Occupation	
Mobile		e-mail	

When did you last receive dental treatment?	

	Tick	Details
Are you attending or receiving treatment from a doctor, hospital, clinic or specialist?		
Are you taking any medicines, tablets, drugs or injections or using any creams, ointments or inhalers?		
Are you taking or have you taken steroids in the last 2 years?		
Are you allergic to penicillin?		
Are you allergic to any medicines, foods or materials?		
Are you pregnant or a nursing mother?		
Have you had rheumatic fever or chorea?		
Have you had jaundice, liver or kidney disease or hepatitis?		
Have you ever been told you have a heart murmur, heart problem, angina or high blood pressure?		
Have you ever had your blood refused by the Blood Transfusion Service?		
Have you ever had a bad reaction to a local or general anaesthetic?		
Have you been hospitalised for any reason?		
Do you have arthritis?		
Do you have a pacemaker or have you had heart surgery?		
Do you suffer from hay fever, eczema, or any other allergy?		
Do you suffer from bronchitis, asthma or other chest condition?		
Do you have fainting attacks, giddiness, blackouts or epilepsy?		
Do you have diabetes or does anyone in your family?		
Do you bruise easily or suffer persistent bleeding following a tooth extraction or injury or does anyone in your family?		
Do you carry a warning card?		
Do you think there are any other aspects concerning your health that your dentist should know about?		

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How long is it since you last visited a dentist?		0 – 6 months		1 – 5 years
		6 – 12 months		Over 5 years
What are your main reasons for coming?		Check-up/Examination		Cosmetic dentistry
		Hygienist/Cleaning		Emergency/Pain
Details / other reasons				

Do you have or have you had any of the following?		Dentures
		Partial Dentures
		Periodontal (gum) treatments
Do your gums ever bleed? When does this happen?		
Are you satisfied with the appearance of your teeth and smile?		
If you could change your smile would you		Have a brighter whiter smile?
		Make your teeth straighter?
		Replace silver metal fillings with tooth coloured restorations?
		Repair chipped teeth?
		Replace missing teeth?
		Replace old crowns that don't match?
		Aspire to have healthier gums?
Are there any questions you would like to ask us?		

Signed	Patient / Parent / Guardian (delete as applicable)	Date	