Dental on the terrace
The friendly dental professionals

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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: _____

Date of Birth_____ Occupation: _____

Mobile Phone: _____**Email**_____

Health Insurance Company_____

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.

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

☐ Yellow Pages	☐ Another patient/friend (Name) _____
☐ Street Sign	☐ Other (Please specify) _____

Signed: Patient/Parent/Guardian _____ Date: _____