**KEW ROAD DENTAL**

**CONFIDENTIAL PATIENT QUESTIONNAIRE**

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

Title: \_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctors Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Are you currently… If yes, please give details**

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| --- |
| Receiving treatment from a doctor, hospital or clinic? **Yes/No** |
| Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including contraceptives and hormone replacement therapy)? **Yes/No** |
| Carrying a medical warning card? **Yes/No** |
| Pregnant or possibly pregnant? **Yes/No** |

 **Have you ever suffered from… If yes, please give details**

­Please turn over

|  |
| --- |
| Allergies to medicines (e.g. penicillin), substances (e.g. latex/rubber) or foods? **Yes/No** |
| Bronchitis, asthma or other chest conditions? **Yes/No** |
| Fainting attacks, giddiness, blackouts, epilepsy? **Yes/No** |
| Heart problems, angina, blood pressure problems, or stroke? **Yes/No** |
| Diabetes (or anyone in family)? **Yes/No** |
| Bone or joint disease? **Yes/No** |
| Bruising or persistent bleeding following tooth extraction or surgery? **Yes/No** |
| Liver disease (e.g. jaundice, hepatitis) or kidney disease? **Yes/No** |
| Cold Sores? **Yes/No** |
| Rheumatic Fever? **Yes/No** |
| Any other serious illness or infectious disease? **Yes/No** |
| Blood refused by the Blood Transfusion Service? **Yes/No** |
| A bad reaction to general or local anaesthetic? **Yes/No** |
| Treatment that required you to be in hospital? **Yes/No** |
| Heart surgery? **Yes/No** |

 **Alcohol / Smoking**

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| How many units of alcohol do you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**units per week**(A unit is half a pint of lager, single measure of spirits or a glass of wine)  |
| Do you smoke any tobacco products? **Yes/ No/ In the past** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_ times per day** |
| Do you chew tobacco, use gutkha or supari  **Yes/No/ In the past** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_ times per day**  |

 **Dental History**

|  |  |  |
| --- | --- | --- |
| What type of toothbrush do you use? (Please tick) |  Manual Electric | Details: |
| Do you use interdental cleaning aids?(Please tick) |  Floss TePe brushes | Frequency: |
| Do you have any fears or anxiety about visiting the dentist that you would like us to be aware of? (Please tick) |  Yes No | Details: |
| How long has it been since your last visit to the dentist… | … for an exam:… for a scale and polish: |

 **Smile Check**

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | Details |
| Are you satisfied with the overall appearance of your teeth? |  |  |  |
| Are you satisfied with the straightness of your teeth? |  |  |  |
| Would you like your teeth whiter? |  |  |  |

**Do you agree with your personal information being shared for healthcare reasons, such as a specialist referral?**

 **Yes No**

**How did you hear about us?**

 □ Internet □ Another patient/friend (Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Street sign □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Completed by: ** self  parent  guardian (Please tick)Patient/Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_Dentist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |