The Dental Gallery
3 The Mall
Ealing
W5 2PJ
Phone: 0208 566 3194

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 D.O.B

Home Address: ____________________ Work Address: ____________________

____________________ ____________________

Post Code: ____________________ Post Code: ____________________

Home Phone: ____________________ Work Phone: ____________________

Mobile: ____________________ Occupation: ____________________

Email Address: ____________________

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
   - ☐ Heart conditions
   - ☐ High or Low Blood Pressure
   - ☐ Jaundice
   - ☐ Arthritis
   - ☐ Hepatitis - Specify type A, B, C
   - ☐ Bronchitis or Chest Problems- Asthma
   - ☐ Severe Headaches
   - ☐ Epilepsy
   - ☐ Anaemia
   - ☐ Diabetes
   - ☐ Kidney or Liver Problems
   - ☐ Gastric Problems
   - ☐ Cold Sores
   - ☐ Depressive Illness
   - ☐ 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. Do you smoke? Yes / No
11. Do you drink alcohol? Yes / No
    If YES, how many units? ____________________

DENTAL HISTORY

1 Approximate date of last dental visit:
   Details: ____________________
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. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

- ☐ Passing by/Live local
- ☐ Another patient/friend (Name) ____________________
- ☐ Website
- ☐ Other (Please specify) ____________________

Signed: Patient/Parent/Guardian ____________________ Date: __________