**Grosvenor Dental Practice**

***CONFIDENTIAL PATIENT QUESTIONNAIRE***

**Title**  **Forename**  **Surname**  **D.O.B.**

**Address**

 **Postcode**

**Contact no.** **Email address**

**Doctor’s Name & Address** **Tel no.**

**Occupation**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICAL HISTORY** | YES | NO | PLEASE PROVIDE DETAILS |
| Are you receiving any Medical Treatment at present? |  |  |  |
| Are you taking any Medicines, Drugs or Injections or using any Creams Ointments or Inhalers? |  |  |  |
| Are you allergic to any Medicines, Foods or Materials? E.g. Penicillin, Latex. |  |  |  |
| Do you carry a Warning Card? |  |  |  |
| Are you Pregnant or a Nursing Mother? |  |  |  |
| Are you HIV positive?  |  |  |  |
| Have you had Jaundice, Liver or Kidney Disease? |  |  |  |
| Have you been diagnosed with Rheumatic Fever, Chorea or Heart defect? |  |  |  |
| Have you ever had a Stroke? |  |  |  |
| Do you suffer from Heart Murmur, Angina, High Blood Pressure or any other Heart Problem? |  |  |  |
| Have you ever had a bad reaction to 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 Allery? |  |  |  |
| Do you suffer from Asthma, Bronchitis or any Chest Problem? |  |  |  |
| Do you have Fainting attacks, Blackouts or Epilepsy? |  |  |  |
| Do you or anyone in your family have Diabetes? |  |  |  |
| Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? |  |  |  |
| Do you think there are Any Other aspects of your health that your Dentist should know about? |  |  |  |

**DENTAL HISTORY**

1. Approximate date of last dental visit:

2. Main reason for attending today?

**SOCIAL HISTORY**

On average, how much of the following do you consume?

**Cigarettes** per day  **Alcoholic drinks** units per week

**HOW DID YOU HEAR ABOUT OUR PRACTICE?**

|  |
| --- |
| **PLEASE GIVE ANY OTHER DETAILS THAT YOU THINK MAY BE RELEVANT OR LIST OF ANY MEDICATIONS CURRENTLY BEING TAKEN** |
|  |

**COMMUNICATIONS CONSENT**

I consent to the practice contacting me for the purposes of health promotion, practice news and for appointment reminders.

|  |  |  |
| --- | --- | --- |
| 🞏 Letter  | 🞏 Telephone/ Text Message | 🞏 Email |
| 🞏 Any of the above | **🞏 None of the above** |  |

I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

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| --- | --- | --- | --- |
| **DATE** | **SIGNATURE** | **DATE** | **SIGNATURE** |
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