SALTFORD
dental practice

Welcome to
Saltford Dental Practice
478 Bath Road,
Saltford
Bristol. BS31 3DJ

CONFIDENTIAL PATIENT QUESTIONNAIRE

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info@saltforddental.co.uk
Find us on Facebook and Twitter

This form provides your Dentist with important information required for your dental treatment and oral health care.

Please write in black ink, block capitals and circle the correct answer

Title:……..

Date of Birth:……./……./…….

First names:……

Surname:……

Home address:……
……
……
……

Postcode:……

Work Address:……
……
……

Work phone number:……

Home phone:……
Mobile phone:……
Email address:……

Details of person to contact in an emergency:
Name:……
Phone number:……

Doctors name:……
Address:……
……
……
……
Phone:……

Medical History

1. Are you receiving any **medical** treatment at the present time? **YES/NO**……
2. Have you been a patient in **hospital** during the past two years? **YES/NO**……
3. Have you taken any **medicine, tablets, capsules** or **drugs** during the past two years? **YES/NO**……
   Please note/provide up to date medication list and dose ……
4. Have you ever, or do you currently take any **steroid** based medication? **YES/NO**……
   If so please provide details. ……
5. Have you experienced any **allergies** or unusual effects from any tablets, drugs, injections or anaesthetics? **YES/NO**……
6. Are you, or have you been under the care of a **doctor** during the past two years? **YES/NO**……
7. Have you had **prosthetic** surgery?(e.g. heart valve or hip replacement) **YES/NO**

   Details:……

8. Have you ever had any of the following? If so please tick as appropriate.

- Rheumatic Fever ☐
- High Blood Pressure ☐
- Gastric Problems ☐
- Bronchitis/Chest Problems ☐
- Severe Headaches ☐
- Anaemia ☐
- Epilepsy ☐
- Diabetes ☐
- Cold sores ☐
- Depressive Illness ☐
- Hepatitis A/B/C ☐
- Asthma ☐
- Arthritis ☐
- Drug Dependence ☐
- Kidney Trouble ☐
- Heart Trouble ☐

9. Women: Are you **pregnant**? If so when is the due date? **YES/NO**

   Due date:……

10. Are you **HIV** positive? **YES/NO**
11. Are you at risk from **HIV** exposure **YES/NO**
12. Do you smoke? **YES/NO** Quantity :……
13. Do you drink alcohol**? YES/NO** Quantity – units per week:……

Dental History

1. Name and address of last Dentist?

   ……..

2. Approximate date of last visit?

   ……..

3. Do you have dental pain or a dental problem at present? **YES/NO**

   Details:……

4. Do you wear dentures? **Yes/No** **Upper/Lower/Both**

   Satisfactory/Unsatisfactory

5. Have you ever experienced excessive **bleeding** or **bruising** from dental treatment, cuts or scratches? **YES/NO**
6. Do you become **anxious** or **uncomfortable** when you are having dental treatment? **YES/NO**
7. *Please indicate on a scale of 0-10, where 0= not at all anxious and 10= petrified, how would you rate your degree of anxiety. This will help your dentist in deciding which treatment modalities are most appropriate for you.* **0 1 2 3 4 5 6 7 8 9 10**
8. How often do you **brush** your teeth? …… Do you use **dental floss**? **YES/NO**
9. How often?.....
10. Would you be happy for a spouse/partner/family member to deal with administrative matters in connection with your appointment? **YES/NO**

Please could you tell us how you found out about registering as a new patient at our practice? *Please circle one of the following*

Leaflet delivery Word of mouth/recommendation Internet Advert Other

Signed by Patient/parent/guardian: …… Date: ……/……/……

Scrutinised by dentist: …… Date: ……/……/……