

OUR QUESTIONNAIRE

Welcome to our practice.

Please fill in your details below.

Your name: _____

Date of birth: _____

Your address: _____

Contact details:

Telephone: _____

Home: _____

Work _____

Mobile: _____

Email: _____

Doctor's name, address and telephone: _____

Your occupation: _____

How did you hear about us ? _____

Beautiful smiles, confident people!

Welling Corner
DENTAL PRACTICE 

To help us plan the best possible care for you, both now and in the future, it will help us to know a little about your previous dental experiences and your hopes and aims for the future.

1. How do you feel about your teeth or their appearance?

2. What is your main concern about your teeth?

3. What are your hopes and aims for your mouth?

4. Do you smoke? NO / YES [delete accordingly]

If YES, how many per day?

5. How many units of alcohol would you normally consume? (Unit is one glass)

Per day? Per week?

6. When did you last see a dentist?

7. Would you say you attend on a regular basis?

8. Is there anything else you would like us to know?

Confidential medical history

To help us treat you safely it is important that we ask you the following questions about your general health. Please answer all question with a 'YES' or 'NO' and if necessary add any additional details. All information provided will be kept strictly confidential.

Are you ...?

1. Under treatment from your doctor, a hospital or clinic NO / YES

Details:

2. Taking any medication (tablets, pills, medicines, inhalers, creams, ointments, injections) NO / YES

Details:

3. Allergic to anything (antibiotics, pollen, rubber, metals, or other substance) NO / YES

Details:

4. Pregnant NO / YES Due date :

Have you ever had... ?

Rheumatic fever or chorea NO / YES

Details :

5. Any heart problems (angina, heart attack, stroke, heart murmur, valve replacement, high or low blood pressure) NO / YES

Details:

6. Any chest problems (bronchitis, asthma, tuberculosis) , NO / YES

Details :

7. Hepatitis (jaundice),liver or kidney disease NO / YES

Details :

8. Epilepsy, fainting or giddiness NO / YES

Details :

9. Any other serious illnesses or been hospitalised NO / YES

Details :

10. A joint replacement NO / YES Details:

11. Blood refused by the transfusion service NO / YES

Details :

Do you ...?

12. Have diabetes NO / YES

Details :

13. Have a heart pacemaker NO / YES

Details :

14. Have arthritis NO / YES Details :

15. Bruise easily or bleed excessively NO / YES

Details :

16. Carry a warning card NO / YES

Details:

17. Do you have, or is there a possibility you may have HIV or AIDS NO / YES

Details:

Patient name: Patient signature:

Date:
