Cambourne Dental Practice

Monkfield House
Monkfield Lane
Gt Cambourne, CB23 6AJ
Phone: 01954 718585
Fax: 01954 718586

CONFIDENTIAL PATIENT QUESTIONNAIRE

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

***If you require a downstairs surgery for wheelchair or disabled access please tick** ☐

Name: _____
Surname First Names Dr / Mr / Mrs / Miss / Ms

Date of Birth _____

Home Address: _____ Work Address: _____

_____ _____

_____ _____

Home Phone: _____ Work Phone: _____

Occupation: _____

Alternate Phone: _____ (Please specify)
(Mobile, Fax, Email, Next of Kin)

Details of person to contact in an emergency:

Name: _____ Phone Number: _____

Medical Doctors Name: _____ Phone (If known): _____

MEDICAL HISTORY

1. Are you taking any medication currently? Please, list below or attach separate list if needed _____ 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	☐ Kidney Trouble	☐ Asthma
☐ Heart Trouble	☐ Gastric Problems	☐ Arthritis
☐ High Blood Pressure	☐ Cold Sores	☐ Epilepsy
☐ Hepatitis - Specify type A, B, C	☐ Depressive Illness	☐ Anaemia
☐ Bronchitis or Chest Problems	☐ Drug Dependence (details pls)	☐ Diabetes
☐ Severe Headaches		

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. Are you at risk to HIV exposure? Yes / No
11. Do you smoke?_____ Yes / No_____ If so, how many per day?_____
12. Do you drink?_____ Yes / No_____ If so, how many units per day?_____

DENTAL HISTORY

1. Name of Last Dentist: _____
2. Approximate date of last dental visit:
   Details: _____
3. Do you have Dental pain or a Dental problem at present? Yes / No
   Details: _____
4. Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? Yes / No
5. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Referred By:

☐ Yellow Pages ☐ Another patient/friend (Name) _____
☐ Street Sign ☐ Other (Please specify) _____

***Please note that you may be taken off if you fail to attend an NHS appointment without 24 hours notice!**

Signed: Patient/Parent/Guardian _____ Date: _____