|  |  |
| --- | --- |
| Bridge Dental Care | *33 Bridge Street*  *Tranent*  *East Lothian*  *EH33 1AH*  *01875 610352*  *info@bridgedental.co.uk* |

***CONFIDENTIAL PATIENT QUESTIONNAIRE***

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  |  |  |

Dr / Mr / Mrs / Miss / Ms

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (If known): \_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

1. Are you receiving any medical treatment or seeing a Doctor? Yes / No

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you been a patient in hospital during the past two years? Yes / No

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you taking any prescribed medication Yes / No

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you experienced any allergies to any food, medicines or anaesthetic? Eg Penicillin or Latex Yes / No

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Rheumatic Fever |  | Epilepsy |
|  | Heart Trouble |  | Anaemia |
|  | High Blood Pressure |  | Diabetes |
|  | Asthma |  | Cancer |
|  | Arthritis |  | Gastric Problems |
|  | Hepatitis - Specify Type A, B, C |  | Hay fever |
|  | Bronchitis |  | Eczema |
|  | Stroke |  | Fainting or Giddiness |

6. Have you had any surgery? (eg Heart Valve or Hip Replacement) Yes / No

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Woman, Are you pregnant? If so, how many months: Due Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

8. Do you carry a medical warning card? Yes / No

9. Do you have bruising or persistent bleeding following an injury, tooth extraction or surgery? Yes / No

10. Do you have any other serious illness that we should know about? Yes / No

11. Do you smoke? If so, please give approx. cigarettes per week Yes / No

12. Do you chew tobacco, pann, gutka or supari now or in the past? Yes / No

13. Do you drink alcohol? If so, please give an approximate unit per week? Yes / No

14. Do you become anxious or uncomfortable when you are having dental treatment? Yes / No

Please note that we have a short notice cancellation policy & also any failed to attend appointments may result in a charge. This is charged at £1.00 a minute.

**Signed:** Patient/Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_