Warsash Dental Practice

Patient Questionnaire

Personal Details

Surname	
Forename	TITLE
Date of Birth	
Tel (home)	
(Mobile)	
(Work)	
Address	
Post Code	
Email (required for recall reminders)	
Nationality	
Occupation	

Doctors Name	
Doctors Practice Address	
Do you smoke?	YES/ NO
Do you ever get cold sores?	YES/ NO
Are you an expectant mother?	YES/ NO

Are You Currently: (please give details)

Receiving treatment from a doctor?
Taking any medicines from your doctor?
Are you allergic to any foods, materials or medicines?

Have you as a child or since: (please give details)

Had rheumatic fever	YES/ NO
Had jaundice, liver or kidney disease or jaundice?	YES/ NO
Have you ever been told you have a heart problem, angina, blood pressure or heart attack/ stroke?	YES/ NO
Had any blood tests, inoculations etc	YES/ NO
Ever had your blood refused by the blood transfusion service?	YES/ NO
Have you ever had a bad reaction to general or local anaesthetic?	YES/ NO
Had a joint replacement?	YES/ NO
Been hospitalised?	

Do You: (please give details)

Believe you are in good health? If no give details	YES/ NO
Have arthritis?	YES/ NO
Have a pacemaker, or other form of heart surgery?	YES/ NO
Suffer hayfever, eczema, or other allergy?	YES/ NO
Suffer Bronchitis, asthma or other chest condition?	YES/ NO
Have fainting, giddiness, blackouts or epilepsy?	YES/ NO
Have Diabetes (or anyone in your family)?	YES/ NO
Suffer from bruising or persistent bleeding?	YES/ NO
Carry a warning card?	YES/ NO
Is there any other aspect of your health your dentist should know about?	

Are you happy for your appointment details to be discussed or arranged by another member of your family? Please circle YES/NO, If yes please state your preferred family member.
Name…….....…

Are you happy for Text Message Appointment Reminders to be sent? YES/NO

Please List Medication Here (PTO if required)

Signature……. Date……..