AYLESTONE HOUSE
Dental Practice
Tel: 0116 283 2701
www.aylestonehouse.co.uk

Confidential Patient Questionnaire

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

Full Name: _____ Dr /Mr/ Mrs/ Miss/ Ms

Home Address: _____

_____Postcode: _____

DOB: _____ Home Phone: _____ Mobile: _____

Email Address: _____ Occupation: _____

GP Name & Surgery: _____ Number (if known) _____

Details of who to contact in an emergency:
Name _____ Relationship to yourself _____ Mobile: _____

Medical History:

Do you have now or have you in the past suffered from: (please tick those that apply)

- o Rheumatic fever
- o Kidney Disease
- o Liver Disease
- o Diabetes
- o Hepatitis
- o Epilepsy
- o Asthma
- o Jaundice
- o Fainting attacks
- o Latex allergy
- o Blackouts
- o Pacemaker
- o Arthritis
- o Cold Sores
- o Hayfever
- o Chorea
- o Chest Problem
- o High blood pressure
- o Heart problems/ heart surgery
- o Penicillin allergy
- o Heart Problems/ heart surgery
- o Drug Dependence
- o Blood or bleeding disorder
- o Hearing impairment
- o Visual impairment
- o Communication problem
- o Learning disability
- o Autism
- o Other…….

Do you have any allergies? Yes/no…. if yes please state what to _____

Have you had any of the following:

- o Bad reaction to GA or LA
- o Had a Blood Borne Infection
- o Recent blood test/ inoculations
- o Taken steroids in the last 2 years
- o Depressive Illness
- o Alcohol Dependency
- o A joint replacement
- o radiotherapy
- o chemotherapy

Mobility issues:

- o Not applicable
- o Wheelchair user
- o Walking Frame
- o Other

If you ticked any of these then Please give more information: _____
Are you a smoker or have you ever smoked in the past? Yes / No / In the past
If yes….How Many cigarettes a day ____
Are you pregnant? Yes/ No Date Due: _____
Approx units of alcohol consumed a week? __ Units (3 units is approx a large glass of wine/pint of beer)
Do you carry a warning card? Yes/ No …..Please give further information_____
Are you seeing a Dr at present? Yes/ No …..Please give further information_____
Are you taking any medication: Yes/ No …..Please list names of drugs if known & what for: _____
_____
_____
_____

Dental History

Previous dentist & practice: _____When did you last see a dentist? Approx_____
Do you have any dental phobias or are you anxious about visiting the dentist? _____

How did you find out about the practice? Yellow pages/ internet/ walking by/ recommended by _____

Signed: Patient/Parent /Guardian: _____ Date: _____