CONFIDENTIAL GENERAL AND HEALTH QUESTIONNAIRE

Mr
Mrs .... Sex ....
Miss Surname First names

Address .... Phone: Home ....

.... Work ....

.... Mobile ....

Email .... School (if applicable) ....

Date of Birth .... /........... /........... Occupation ....

Parents/Guardians names if under 16 ....

PLEASE ANSWER ALL QUESTIONS

If your answer is YES to the question, tick the box marked YES

If your answer is NO to the question, tick the box marked NO

All questions to be answered by, or on behalf of the patient.

Who is your regular doctor? ....

Question			YES	NO
Are you being treated for any health-related condition now?			YES ❑	NO ❑
Are you taking any tablets, capsules, medicine or drugs now?			YES ❑	NO ❑
If so, please list				
Or in the last six months?			YES ❑	NO ❑
Have you ever had any of the following:				
	Cardiovascular:	Angina	YES ❑	NO ❑
		Heart murmur	YES ❑	NO ❑
		Rheumatic fever	YES ❑	NO ❑
		Heart surgery	YES ❑	NO ❑
		High blood pressure	YES ❑	NO ❑
		Stroke	YES ❑	NO ❑
	Respiratory:	Asthma	YES ❑	NO ❑
		Chest & Lung disease	YES ❑	NO ❑
		Sinus/hay fever	YES ❑	NO ❑
	Other:	Epilepsy	YES ❑	NO ❑
		Diabetes	YES ❑	NO ❑
		Kidney problems	YES ❑	NO ❑
		Gastric problems	YES ❑	NO ❑
		Depressive illness	YES ❑	NO ❑
		Radiotherapy/Chemotherapy	YES ❑	NO ❑
Have you ever had any allergies to medicines or other substances (such as Latex)? If so, please list			YES ❑	NO ❑
Do you have an artificial or prosthetic joint? If so, when was surgery?			YES ❑	NO ❑
Are you taking or have taken in the last 10 years Bisphosphonate medication (treatment for osteoporosis/multiple myeloma/bone diseases)?			YES ❑	NO ❑
Do you smoke? If so, how many per day?			YES ❑	NO ❑

PTO

Have you ever experienced excessive bleeding or bruising from dental treatment, or at any other time?		YES ❑	NO ❑
Have you ever had contact with:	HIV virus	YES ❑	NO ❑
	Hepatitis B virus	YES ❑	NO ❑
	Hepatitis C virus	YES ❑	NO ❑
Have you ever had an unfavourable reaction to an anaesthetic?		YES ❑	NO ❑
Women: Are you pregnant now?		YES ❑	NO ❑
If so, how many weeks			
Do you consent to the use of amalgam restoration in posterior teeth?		YES ❑	NO ❑
Are there any other health matters you need to talk to the dentist about?		YES ❑	NO ❑
Is there anything you are unhappy about with your teeth/smile?		YES ❑	NO ❑
If so, what?			
Do you have any concerns/questions regarding dentistry?....................		YES ❑	NO ❑
If so, what?			
Are you nervous or worried regarding any aspects of dental treatment?		YES ❑	NO ❑

NEW PATIENTS

How did you hear about us	Referred from a friend	YES ❑	NO ❑
	Referred from a dentist	YES ❑	NO ❑
	Yellow Pages	YES ❑	NO ❑
	Other..		

MISSION STATEMENT:
Our aim at QE2 Dental is to provide excellent dental care and service in a friendly, professional environment. For any reason if you feel that you have not received care and treatment to a high level then please inform us so we can do something about it.

PAYMENT:
Payment is required at the time of treatment unless prior alternatives have been arranged.
If the account is unpaid after 28 days, the outstanding balance will be forwarded to a professional debt collection agency. Any further expenses incurred by this are your responsibility.

I have completed the General and Health Questionnaire correctly.

Signed:.. Patient/Parent/Guardian Date ..../........./.........

Patients under 16 need to have the declaration signed by a parent or guardian.

Staff check:.. Date ..../........./.........