Patient Questionnaire

ORN MARKET DENTAL

TITLE:			
FIRST NAME:			
SURNAME:			
DATE OF BIRTH:	HOME TEL: MOBILE TEL:		
HOME ADDRESS:			
POSTCODE:			
EMAIL:			
OCCUPATION:			
IF STUDENT SCHOOL/COLLEGE ATTENDING			
YOUR DOCTORS NAME:			
DOCTORS PRACTICE NAME:			
DOCTORS PRACTICE ADDRESS:			
POSTCODE:			
HOW DID YOU HEAR ABOUT THE PRACTICE?			
ONLINE		WORD OF MOUTH	
YELLOW PAGES		WEBSITE	
LEAFLET		OTHER (Please specify)	
WHO MAY WE THANK YOU FOR INTRODUCING YOU?			
SIGNATURE:		DATE:	

ORN MARKET DENTAL

OPTIONAL QUESTIONS			
HOW OFTEN DO YOU BRUSH YOUR TEETH AND FOR HOW LONG?			
TWICE A DAY		ONCE A DAY	
WHEN I REMEMBER		MORE THAN TWICE A DAY	
HOW OFTEN DO YOU FLOSS OR USE OTHER INTER-DENTAL PRODUCTS?			
TWICE A DAY		ONCE A DAY	
WHEN I REMEMBER		MORE THAN TWICE A DAY	
WHEN BRUSHING YOUR TEETH DO YOU EVER HAVE ANY BLEEDING FROM THE GUMS?			YES NO
DO YOU HAVE ANY CURRENT CONCERNS WITH YOUR TEETH?			YES NO
WOULD YOU CONSIDER YOURSELF AS A NERVOUS DENTAL PATIENT?			YES NO
WHAT MAKES YOU NERVOUS?			
WHEN DID YOU LAST VISIT THE DENTIST?			
HAVE YOU EVER VISITED THE HYGENIST?			
IF YOU HAVE ANY CROWNS/BRIDGES/IMPLANTS OR DENTURE PLEASE LIST:			
ARE YOU HAPPY WITH YOUR SMILE?			YES NO
IF NOT, WOULD YOU LIKE TO DISCUSS THE OPTIONS AVAILABLE TO YOU?			YES NO
WE OFFER TEETH WHITENING, IS THIS SOMETHING YOU WOULD LIKE TO DISCUSS?			YES NO
WE OFFER TEETH STRAIGHTENING, IS THIS SOMETHING YOU WOULD LIKE TO DISCUSS			YES NO
WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER AND OTHER PRACTICE UPDATES BY EMAIL?			YES NO

Medical History

Units of alcohol
1pint=3units, Wine 175ml = 2 unit, Alcopop 1.4 units, single spirit = 1 unit, Bottle wine = 10 units

HABITS			
	Qty		
Smoke (per day)		High sugar diet	Y/N
Chew Tobacco (per day)		Frequent fizzy drinks	Y/N
Alcohol Units (per week)		Recreational drugs	Y/N
Details			

HEART			
Rheumatic fever	Y/N	Heart Murmur	Y/N
High Blood Pressure	Y/N	Angina	Y/N
Heart surgery	Y/N	Thrombosis	Y/N
Pacemaker Fitted	Y/N	Other heart conditions	Y/N
Details			

BLOOD			
Hepatitis B	Y/N	Anaemia	Y/N
H.I.V	Y/N	Sickle cell	Y/N
Abnormal Blood Test	Y/N	Haemophilia	Y/N
Blood refused by transfusion service	Y/N	Other blood conditions	Y/N
Details			

ALLERGIES			
Penicillin	Y/N	Latex Allergy	Y/N
Hay Fever	Y/N	Medicines	Y/N
Anti Tetanus Serum	Y/N	Plants	Y/N
Eczema	Y/N	Foods	Y/N
General Anaesthetic	Y/N	Aspirin	Y/N
Local Anaesthetic	Y/N	Other Allergy Conditions	Y/N
Details			

WARNINGS			
Pregnant or possibly pregnant	Y/N	Do not Recline	Y/N
Antibiotic Cover Required	Y/N	Steroids within 2 years	Y/N
Bruising or persistent bleeding	Y/N	Warning card	Y/N
Currently under Treatment	Y/N	Treatment Req Hospitalisation	Y/N
Anything Dentist should know	Y/N		
Details			

CHEST			
Bronchitis	Y/N	Emphysema	Y/N
Cystic fibrosis	Y/N	Pneumonia	Y/N
Pleurisy	Y/N	Chest surgery	Y/N
Asthmatic	Y/N	Other chest conditions	Y/N
Details			

MEDICATION List

OTHER			
Liver Disease	Y/N	Kidney disease	Y/N
Diabetes	Y/N	Epilepsy	Y/N
Acid Reflux or eating Disorder	Y/N	Hiatus Hernia	Y/N
Bone or joint disease	Y/N	Artificial joint	Y/N
Fainting attacks or blackouts	Y/N	Giddiness	Y/N
Past serious or infectious disease	Y/N	Cancer	Y/N
Details			

Signature: .... Date: ....

Name ....

DOB: ....