



NEW PATIENT QUESTIONNAIRE

Title (Mr/Mrs/Miss/Ms)	
Surname	
Forename	
Address	
Postcode	
Tel no. (home)	
Tel no. (business)	
Date of Birth	
Occupation	

We ask you to complete this form as certain medical conditions can affect dental treatment and vice versa. All details will be strictly confidential

	Yes	No
Do you have or have you ever suffered from:		
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
Any heart complaint (including heart murmur)?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis or asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Any other serious illness?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any medicine or tablets? (list below in notes)	<input type="checkbox"/>	<input type="checkbox"/>
Are you at present:		
taking any medicine or tablets? (list below in notes)	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Are you the mother of a child under 12 months?

In the past 2 years have you:

undergone any operations?

been treated with hydro-cortisone or corticosteroids?

Have you ever had a joint replacement operation?

Do you have a close relative who has, or has had, CJD?

Did you receive growth hormone treatment before the mid-1980's?

Have you ever had brain surgery?

Please tick or tell the dentist if you are HIV positive

If 'yes' to any questions please supply details in 'Notes' below or use back of form

What is your average weekly consumption of alcohol?

If you smoke, what is your average per week?

Notes (continue on back of form if necessary)

Name and address of your doctor:

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Patients signature

Date