Cowley Dental Practice

Advanced Dental Care

Confidential Patient Questionnaire

This provides the Dentist with important information required for your Dental treatment and Oral Health Care.

Title: _____ First Name: _____Surname: _____
Home Address:_____
_____ Post Code: _____
Date of Birth:_____ E-mail: _____
Home Phone: _____ Mobile: _____
Occupation: _____
Details of person to contact in an emergency:
Name: _____ Phone Number: _____

Medical History

Are you receiving any medical treatment at present time? Details:

_____

Have you been a patient in hospital during the past two years? Details:

_____

Have you taken any medicine tablets, capsules or drugs during the past two years?
Details: _____
Any allergies or unusual effects from tablets/antibiotics/injections/anaesthetic?

_____

Are you or have you been under the care of a GP/Consultant during the past three years? Details: _____

Have you had any of the following? If so, please tick as appropriate:

- ☐ Rheumatic fever
- ☐ Heart trouble
- ☐ Previous
- ☐ Epilepsy
- ☐ Prone to fits/faints/blackouts
- ☐ Allergies? Latex/ Penicillin etc, please specify: ____
- ☐ HIV positive (or at risk)
- ☐ High / Low Blood Pressure, please specify: ____
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis A, B, C, Type __
- ☐ Bronchitis/chest problems
- ☐ Headaches/migraines
- ☐ Anaemia
- ☐ Diabetes, Type __
- ☐ Cold Sores
- ☐ Kidney trouble
- ☐ Gastric problems
- ☐ Depression
- ☐ Drug use

Have you had any prosthetic surgery? (eg. Heart valve or hip replacement) _____
Women, are you pregnant? Yes/No, if so how many months: ___
Do you bleed excessively? Yes/No
Do you smoke? Yes/No how many? _____ Weekly alcohol Intake _____

Please be aware that our dental chairs have a maximum weight limit of135kg (21st). If you think you exceed this limit, please inform the dentist.
I consent to Lechlade Dental Practice calling/leaving an answer phone message or message with a family member with the details of my dental appointment time and date. I am also aware that there is a late cancellation charge applied if I fail to give less than 24 hours' notice to cancel my appointment.

Signature: _____ Date: _____