Welcome to
Porthmadog Dental Centre
76 High St
Porthmadog
Gwynedd
LL49 9NW

CONFIDENTIAL PATIENT QUESTIONNAIRE

www.porthmadogdentalcentre.co.uk

This form provides your Dentist with important information required for your dental treatment and oral health care.
Please write in black ink, block capitals and circle the correct answer

Title: …..
First Names: …….
Surname: ……..

Date of Birth: ……../……../……..

Home Address: …….
……...
……...
Postcode: …….

Work Address: ……
…….
…….
Postcode: …….

Home Phone: …….

Work Phone: ……

Mobile Phone: ……

Details of person to contact in an emergency:

Name: …….

Phone Number: ……

Doctor's Name: ……

Phone Number: ……

Medical History

1) Are you receiving any **medical treatment** at the present time?
Yes/No
Details: ……

2) Have you been a patient in **hospital** during the past two years?
Yes/No
Details: ……

3) Have you taken any **medicine, tablets, capsules** or **drugs** during the past two years?
Please note tablet and dose
Yes/No
Details: ……

4) Have you ever, or do you currently take any **steroid** based medication? If so please provide details.
Yes/No
Details: ……

5) Have you experienced any **allergies** or unusual effects from any tablets, drugs, injections or anaesthetics?
Yes/No
Details: ……

6) Are you, or have you been under the care of a **doctor** during the past two years?
Yes/No
Details: ……

Please turn over ……

7) Have you ever had any of the following?
If so please tick as appropriate.

Rheumatic Fever ☐	**Epilepsy** ☐	**Heart Trouble** ☐	**Anaemia** ☐
High Blood Pressure ☐	**Diabetes** ☐	**Asthma** ☐	**Kidney Trouble** ☐
Gastric Problems ☐	**Cold Sores** ☐	**Arthritis** ☐	**Hepatitis A/B/C** ☐
Bronchitis/Chest Problems ☐	**Depressive Illness** ☐	**Drug Dependence** ☐	**Severe Headaches** ☐

9) Have you had **prosthetic surgery**? (e.g. heart valve or hip replacement? Yes/No
Details: ……

10) Women: Are you **pregnant**? If so when is the due date? Yes/No
Due Date: ……

11) Are you **HIV** positive? Yes/No

12) Are you at risk from **HIV** exposure? Yes/No

13) Do you **smoke**? Yes/No Quantity: ……

14) Do you drink **alcohol**? Yes/No Quantity – units per week: …….

Dental History

1) Name and address of last Dentist? ……..

2) Approximate last date of visit? ……

3) Were you registered as;
A) Private B) Denplan/other C) NHS? (Delete as applicable)

4) Do you have **dental pain** or a dental problem at present? Yes/No
Details:……....…….....……..……

5) Do you wear dentures? Yes/No
Upper/Lower

6) Do you find these satisfactory? Yes/No

7) Have you ever experienced excessive **bleeding** or **bruising** from dental treatment, cuts or scratches? Yes/No

8) Do you become **anxious** or **uncomfortable** when you are having dental treatment? Yes/No
Please indicate on a scale of 0 to 10, where 0 = not at all anxious and 10 = petrified, how you would rate your degree of anxiety.

0 1 2 3 4 5 6 7 8 9 10
This will help your dentist in deciding which treatment modalities are most appropriate for you.

9) How often do you **brush** your teeth? …….

10) Do you use dental **floss**? Yes/No How often …….

Please could you tell us how you heard about our practice? ……
Signed: Patient/Parent/Guardian: …….. Date: ……../……../……..

Scrutinised by Dentist: ..... Date: ...../...../.....