Wyndcott Dental Centre

Birchwood Park Avenue
Swanley, Kent
BR8 7AT
01322 662493
www.wyndcottdental.co.uk

CONFIDENTIAL PATIENT QUESTIONNAIRE

This provides the dentist with important information required for your Dental treatment and Oral Health Care.
Sections in plain black are required for every check-up. Please update details in *blue italics* if they change.

Mr / Mrs / Miss / Ms/ Mstr First Names_____ D.O.B._____

Surname _____

Home Address: _____

_____ *Post code:* _____

Home Phone: _____

Mobile Phone: _____ *Occupation:* _____

Email (parent or guardian if under 16) _____

We use email and/or SMS to send appointment reminders. May we also send information about offers ? ☐ *Yes*

Contact Preference: ☐ *Home Phone* ☐ *Mobile Phone* ☐ *Email* ☐ *SMS/Text* ☐ *Post*

Emergency contact name: _____ Phone Number: _____

Doctor's Name: _____ Practice: _____ Town: _____

MEDICAL HISTORY

1. Have you been a patient in hospital or been to a Doctor's during the past two years? Please describe if yes.

   ☐ No ☐ Yes _____

2. Have you taken any prescription medicine (tablets, capsules) during the past two years? Please list medication.

   ☐ No ☐ Yes _____

   _____

3. Do you have any allergies? (E.g. from any medicines, anaesthetics, food, latex?)

   ☐ No ☐ Yes _____

4. Have you had any of the following? (Tick all boxes that apply).

☐ Rheumatic fever	☐ Epilepsy	☐ Arthritis
☐ Heart trouble	☐ Anaemia	☐ Depression
☐ High blood pressure	☐ Diabetes	☐ Thyroid problems
☐ Asthma	☐ Kidney trouble	☐ Biphosphonates
☐ Hepatitis type: ☐ A ☐ B ☐ C	☐ Gastric problems	☐ Cold sores
☐ Bronchitis or chest problems	☐ Severe headaches	☐ Drug dependence
☐ Aspirin as a blood thinner	☐ Any other blood thinner	☐ Warfarin

5. Have you had any prosthetic surgery or any other serious problems? (E.g. Heart Valve or Hip Replacement, Broken back)

   ☐ No ☐ Yes _____

6. Are you pregnant? ☐ No ☐ Yes: _____ months

7. Are you HIV positive or at risk of exposure? ☐ No ☐ I am HIV positive ☐ I am at risk of exposure to HIV

8. What concerns do you have? ☐ Crooked teeth ☐ Colour ☐ Missing Teeth ☐ Snoring ☐ Metal Fillings ☐ Other

9. Do you smoke or vape? ☐ No ☐ Quit: (when) _____ ☐ Yes: _____ per day

10. Would you like help to quit smoking? ☐ No ☐ Yes

11. Do you drink alcohol? ☐ No ☐ Yes: _____ units per week (average)

12. Do you weigh more than 21stones / 135Kg ☐ No ☐ Yes: _____ (we may have to refer you for treatment)

Signed: Patient / Parent / Guardian _____ Date: _____