# HIGH ASH DENTAL SURGERY

## Confidential patient questionnaire

This provides the dentist with important information required for Dental Treatment and Oral Health Care.

NAME: _____
ADDRESS: _____
POSTCODE: _____
MR/MRS/MS/MST/MISS/MX
DATE OF BIRTH: _____
MOBILE NUMBER: _____
EMAIL: _____

OCCUPATION: _____
WORK ADDRESS: _____
WORK CONTACT NUMBER: _____
NHS NUMBER: _____
HOME PHONE: _____

**DETAILS OF A PERSON TO CONTACT IN AN EMERGENCY:**

Name of a person to contact:
Contact number address:
Relationship to yourself:
Mobile: _____

Doctors details: _____
Address: _____
Telephone: _____

**Do you have any known allergies i.e. latex, nuts, etc.?**
**_____**

**MEDICAL HISTORY**

Are you receiving any medical treatment at the present time? YES/ NO
Details: _____

Have you been a patient in hospital during the past two years? YES/NO
Reason: _____

Are you taking any medicine, tablets, capsules or drugs including the past year? YES/NO
Details: _____

Have you experienced any allergies or unusual effects from any tablets, drugs, injections or **anaesthetic**? YES/NO
Details: _____

Are you currently taking, or have ever taken: Warfarin YES/NO Bisphosphonates YES/NO

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rheumatic fever | | Arthritis | | Drug dependence | | Bronchitis or chest problems | |
| Heart problems | | Anaemia | | Gastric problems | | Severe headaches | |
| High blood pressure | | Diabetes | | Cold sores | | Mental health issues | |
| Asthma | | Epilepsy | | Kidney trouble | | Hepatitis-specify type A,B,C | |

Have you had any prosthetic surgery? (E.g. Heart valve or Hip replacement) YES/NO
Details: _____

Are you HIV positive? YES/NO Are you at risk to HIV exposure? YES/NO

Are you or could you be pregnant? YES/NO

Have you ever experienced excessive bleeding or bruising from dental treatment, cuts or scratches? YES/NO

Do you become anxious or uncomfortable when you are having dental treatment? YES/NO

Would you rate your sugar intake as: HIGH/MEDIUM/LOW?

How many times a day do you brush your teeth?

Do you floss or use interdental brushes? YES/NO If yes how many do you use each day on average_____

Do you smoke tobacco products or vape? YES/NO If yes how many do you use each day on average_____

How many units of alcohol do you consume each week on average:_____

Do you have any special or communication needs relating to a disability, impairment or sensory loss and how these needs might be best met? _____

**Please complete the tables below if you exceed the government recommended 14 units per week:**

This alcohol harm assessment tool consists of the consumption questions from the full alcohol use disorders identification test (AUDIT).

| Questions | Scoring system | | | | | Your score |
|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times per month | 2 to 3 times per week | 4 or more times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 0 to 2 | 3 to 4 | 5 to 6 | 7 to 9 | 10 or more | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |

How many hours sleep do you get on average each night? _____

Do you have disturbed sleep? _____

Do you wake up with headaches or jaw pain? _____

**Are you interested in any dental cosmetic procedures such as composite bonding or facial aesthetics?**

**YES/NO**

**SIGNED:** Patient/Parent/Guardian: _____

Date:

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