Practice Questionnaire

All information will be kept confidential within the terms of Butt Lane Dental Surgery Confidentiality Policy

Mr ☐ Mrs ☐ Miss ☐	Surname	Forename	Date of Birth
Address			

Telephone Number	Mobile Number	Email Address
Occupation	**Work Tel No. or Address**	**Doctors Name & Address**

Certain medical conditions can affect dental treatment and vice versa

1. Have you ever suffered from: (Please tick)

	Yes	No
a) Rheumatic Fever?	☐	☐
b) Any heart complaints?	☐	☐
c) Diabetes?	☐	☐
d) Epilepsy?	☐	☐
e) Chronic Bronchitis or Asthma?	☐	☐
f) Jaundice?	☐	☐
g) Blood disorder?	☐	☐
h) Excessive bleeding?	☐	☐
i) High blood pressure?	☐	☐

2. Have you ever suffered from any other serious illness? If so, please specify.

3. Are you allergic to any medicines or tablets? If so, please specify.

4. Are you at present taking any medicines or tablets? If so, please specify.

5. Have there been any changes in your health or medication since you last visited the dentist?

6. Are you pregnant? If so please provide the expected date of birth.

7. Do you smoke? If so how many per day.

8. Do you drink alcohol? If so, approximate units per week.

Sign -- Date --------------------------------------