Version June 2020

BERKHAMSTED DENTAL PRACTICE

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Caring for your family's teeth

CONFIDENTIAL HEALTH QUESTIONNAIRE

Please complete so that we can provide you with the best possible care

Title	Forenames	Surname:
Date of Birth / /	Address	
Tel (home)	Tel (work) Tel (mobile)	Email Occupation

We would like to contact you to remind you about appointments. **Please indicate if you want to be contacted by**: Phone/Answerphone ☐ Mobile phone ☐ Email ☐

Previous dentist's name & address: How long since last received dental treatment?

Doctor's name & address :

How did you hear about the practice? Were you recommended to the practice? By whom?

We are committed to providing accessible information. Please indicate here if you have any special information or communication needs:

We may want need to communicate with other health care providers, insurers etc by email. Please tick box if you consent to us sending personal identifiable information by e mail ☐

As part of your treatment we may take photographs as part of your clinical records. Tick box if you are happy to allow these to be used for educational: ☐ or promotional: ☐purposes

Are you: Currently receiving treatment from a doctor, hospital, clinic or specialist?	**NO**	**YES**	**If YES, please give details**
Taking any medicines, tables, ointments, inhalers or injections, including HRT or contraceptives?			
Carrying a health-warning card?			
If female; are you, or could you be pregnant?			
Do you, or have you suffered from: Allergies to any medicines, foods or other materials; in particular antibiotics, anaesthetics & pain killers; latex rubber gloves, household cleaning agents and seafood?			
Hay fever or eczema?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Diabetes? Do any close relatives suffer with diabetes?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases including HIV?			
High or low blood pressure?			
Asthma of other lung problems?			
Rheumatic fever or chorea (St. Vitus Dance)?			
Cold sores?			
Thyroid disease?			
Liver disease?			
Any other serious illnesses?			
Please complete & return the Covid-19 self-assessment form **the day before** your appointment			

Have you ever had: Blood refused by the Blood Transfusion Service?	**NO**	**YES**	**Details**
A bad reaction to local anaesthetic?			
Steroids; in particular in the last 2 years?			
A joint replacement or any other form of implant?			
Heart surgery, including heart valve replacement?			
Brain surgery prior to 1986?			
A close relative who has or may have had CJD?			
Any other hospital treatment?			
Alcohol & smoking? Do you drink alcohol? If yes, how many units per week?			
Do you smoke tobacco products now or did you in the past?			
Do you chew tobacco, pan or supari now or did you in the past?			
Please give any other details that may be relevant, such as self-prescribed medicines (e.g. Aspirin)			

Completed by: Self / Parent / Guardian / Representative
Delete as appropriate

Signature…….. Date:……..
Updated (sign & date)…….
Updated (sign & date)…….

We treat all personal information about patients as confidential. If you would like to see our Privacy notice & Confidentiality Policy please ask.