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 block capitals

CHILD PATIENTS AGED UNDER 16 YEARS

First Names: …………………………….

Surname: ………………………………..

Date of Birth: ……../……..../……….

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

Home Phone: …………………………….

Details of person to contact in an emergency:

Name: ……………………………………. Phone Number: ……………………

Doctor's Name: …………………………… Phone Number: ……………………

Medical History

1) Is your child receiving any **medical treatment** at the present time?
Yes/No
Details: ……………………………………

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

3) Has your child taken any **medicine**, **tablets**, **capsules** or **drugs** during the past two years?
Yes/No
Details: ……………………………………

4) Has your child ever, or does your child currently take any **steroid** based medication? If so please provide details.
Yes/No
Details: ……………………………………

Please turn over ………….

5) Has your child ever experienced any **allergies** or unusual effects from any tablets, drugs, injections or anaesthetics? Yes/No
Details: ……………………………………

6) Is your child, or has your child been under the care of a **doctor** during the past two years? Yes/No
Details: ……………………………………

7) Has your child 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/HIV** ☐
Bronchitis/Chest Problems ☐	**Depressive Illness** ☐	**Drug Dependence** ☐	**Severe Headaches** ☐

8) Has your child had **prosthetic surgery**? (e.g. heart valve or hip replacement? Yes/No
Details: ……………………………………

Dental History

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

2) Approximate last date of visit? ……………………………

3) Does your child have **dental pain** or a **dental problem** at present? Yes/No
Details:……....…………………………………......……………………………………..………………

4) Has your child ever experienced **excessive bleeding** or bruising from **dental treatment**, cuts or scratches? Yes/No

5) Does your child feel **anxious** or **uncomfortable** when they are having dental treatment? Yes/No

6) How often does your child **brush** his/her teeth?
…………………………………………………………………….

7) Does your child use dental **floss**? Yes/No How often?
……………………………….

Referred By

Please could you tell us how you heard about our practice? ………………………………

Signed: Parent/Guardian: ………………………….. Date: ……../……..../……..

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