

# General Consultation Questionnaire



diamonddental  
@ Westbury Park

Name:				Ms/Miss/Mrs/Mr <i>(delete as appropriate)</i>
Address:				
Postcode:		D.O.B.		
Mobile		Home Tel No.		
Occupation:		Email:		
Do you smoke?	Yes / No	How many per day?		
If No, have you ever smoked?	Yes / No	When did you give up?		
Height:		Current Weight		
Are you trying to lose weight?	Yes / No	If Yes, how much?		
Do you have a special diet?				Yes / No
If Yes, is it Vegetarian / Vegan / Gluten Free / Other <i>(delete as appropriate)</i>				
Do you take regular exercise?				Yes / No
If Yes, what type of exercise do you do?				
How many days per week do you exercise for 20 minutes or more?				
Do you drink alcohol?				Yes / No
If Yes, how many units per week? <i>(one unit = ½ pint of lager, small glass of wine, small spirit)</i>				
Are you pregnant or breast-feeding?				
Are you currently taking or have ever taken any of the following medications:				
Laxatives / Vitamin E	Yes / No	St John's Wort	Yes / No	
Hormones / Contraceptive pill	Yes / No	Gentamicin / Neomycin	Yes / No	
Steroids / gold injections	Yes / No	Roaccutane	Yes / No	
Aspirin / painkillers	Yes / No	Anti-coagulants	Yes / No	
If Yes to any of the above, please give details:				

<b>Please list any medication you are taking (including supplements):</b>			
<b>Are you allergic to any of the following?</b>			
<b>Plasters</b>	Yes / No	<b>Stitches</b>	Yes / No
<b>Iodine</b>	Yes / No	<b>Local Anaesthesia</b>	Yes / No
<b>Antibiotics</b>	Yes / No	<b>Beef / Pork</b>	Yes / No
<b>If Yes, please give details:</b>			
<b>Are you currently undergoing any desensitisation treatment?</b>			Yes / No
<b>If Yes, for which allergen?</b>			
<b>Have you suffered from any of the following?</b>			
<b>Heart Disease / Angina</b>	Yes / No	<b>Thyroid Problems</b>	Yes / No
<b>Auto-immune Disease</b>	Yes / No	<b>Arthritis</b>	Yes / No
<b>Asthma / Bronchitis</b>	Yes / No	<b>Convulsions</b>	Yes / No
<b>Facial Cold Sores</b>	Yes / No	<b>Depression</b>	Yes / No
<b>High / Low Blood Pressure</b>	Yes / No	<b>Diabetes</b>	Yes / No
<b>Stomach Ulcer / Colitis</b>	Yes / No	<b>Skin Disease e.g. acne</b>	Yes / No
<b>HIV / Hepatitis</b>	Yes / No	<b>Glaucoma / Cataract</b>	Yes / No
<b>Venereal Disease</b>	Yes / No	<b>Bell's / Facial Palsy</b>	Yes / No
<b>Phlebitis</b>	Yes / No	<b>Hypoglycaemia</b>	Yes / No
<b>Do you have any neuromuscular disorders or defects?</b> e.g. Myasthenia Gravis, Eaton Lambert or Amyotrophic Lateral Sclerosis			Yes / No
<b>Do you suffer from a bleeding disorder? e.g. haemophilia</b>			Yes / No
<b>Have you had any previous surgery?</b>			Yes / No
<b>If Yes, please give details:</b>			
<b>Have you ever been admitted to hospital?</b>			Yes / No
<b>If Yes, please give details:</b>			

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_