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| **PATIENT ASSESSMENT FORM** |
| Title:  | Forename: | Surname: |
| Address: |
| Postcode: | Email: |
| Telephone: | Mobile: |
| Occupation: | Date of Birth: |
| **MEDICAL DOCTOR’S DETAILS** |
| Name: |
| Address: |
| Postcode: | Contact No: |
| **NEXT OF KIN** |
| Name:  | Contact No: |
| **COVID-19 ASSESSMENT** |
| **Do you have any symptoms of COVID-19?** Yes [ ]  No [ ]  If YES, please specify: Persistent cough [ ]  Shortness of breath [ ]  Loss of taste/sense of smell [ ]  Fever above 37.8 [ ]  Diarrhoea [ ]  |
| **Are you quarantining for any reason?** Yes [ ]  No [ ]  If YES, please specify: |
| **Is anybody in your household currently self-isolating?** Yes [ ]  No [ ]  |
| **Have you recently travelled abroad in the last 2 weeks?** Yes [ ]  No [ ] If YES, please specify where: |
| **How many COVID-19 vaccine doses have you received?** |
| **DETAILS FOR EMERGENCY If this doesn’t apply to your upcoming visit, please go to the next page** |
| **What is your main problem?** *Lost filling* [ ]  *Broken tooth* [ ]  *Lost/broken crown*[ ]  *Abscess* [ ]  *If other, please specify:* |
| **Are you experiencing any pain or other symptoms?** *Aching* [ ]  *Throbbing* [ ]  *Swelling* [ ] *If other, please specify:* |
| **Is this problem affecting any of the following?** *Eating* [ ]  *Swallowing* [ ]  *Sleeping* [ ] *If other, please specify:* |
| **Have you been taking any of the following to improve your condition?** *Antibiotics* [ ]  *Painkillers* [ ] *If other, please specify:* |
| **MEDICAL HISTORY CHANGES - If you have attended in the practice in the last two years, please indicate any or no changes in the box below** |
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| **COMPREHENSIVE MEDICAL HISTORY - For all new patients and patients who have not attended the practice for 2 years or more, please complete the questionnaire below** | **YES** | **NO** |
| Are you pregnant? |[ ] [ ]
| Do you carry a medical warning card or do you have a pacemaker? |[ ] [ ]
| Do you suffer any allergies to food, or medicines (e.g. penicillin) or substances (e.g. latex/rubber)? |[ ] [ ]
| Do you suffer from persistent bleeding following injury or have any blood disorders (e.g. haemophilia)? |[ ] [ ]
| Do you have diabetes, rheumatoid arthritis or any other autoimmune disease? |[ ] [ ]
| Are you receiving treatment from a doctor, hospital or clinic? |[ ] [ ]
| Have you been hospitalised for any serious illnesses? |[ ] [ ]
| Do have/had any heart problems, angina, blood pressure, a stroke or heart murmur? |[ ] [ ]
| Have you ever had rheumatic fever or a history of infective endocarditis? |[ ] [ ]
| Do you had/had liver disease (e.g. Jaundice, hepatitis) or kidney disease? |[ ] [ ]
| Do you have/had hay fever, eczema, asthma, bronchitis, or other chest conditions? |[ ] [ ]
| Have you been diagnosed with osteoporosis? |[ ] [ ]
| Do you have any close relatives’/family members with Creutzfeldt Jakob disease? If so, who? |[ ] [ ]
| Do you smoke or use any tobacco products?  |[ ] [ ]
| If you do smoke, how many per day? |  |
| If use consume alcohol, how many units per week? |  |
| *Medication taken:**Please provide further details of your illness/condition:* |
| **CONSENT** |
| **I consent for the dentist to phone me for the purposes of a telephone or video consultation should it be required. The conversation via video or phone may be recorded in my practice notes.****I consent to clinical photographs being taken.****I accept that despite all risk assessment and safe guarding/cross-infection procedures in place, there is a risk of contracting COVID-19.** |
| **SIGNED:** | **DATED:** |