|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | | | | | |
|  | | | | | | | |
| **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:** | | | |