JASMINE DENTAL STUDIOS Confidential Medical History Form

**Please note that until you have attended an initial appointment you will not officially be a patient of the practice.**

**Cancellations and Failing to attend.** If you are unable to attend your appointment please let the practice know with a minimum of 24 hours’ notice. If you fail to attend on more than one occasion then you may be removed from the practice list and need to seek alternative dental services elsewhere. We will of course take any special circumstances into account.

Your information will always be kept in the strict confidence.

**PLEASE COMPLETE IN BLOCK CAPITALS**

|  |
| --- |
| **Title:** |
| **Male**/**Female**: |
| **Date of Birth**: |
| **First Name:** |
| **Surname:** |
| **Address:** |
| **Post code:** |
| **Email Address:** |
| **Telephone Numbers:** |
| Home: |
| Mobile: |
| Work: |
|  |
| **Occupation/School:** |
| **Nationality:** |
| **First Language:** |
|  |
| **Doctor’s Surgery:** |
| Practice Name: |
| Address: |
| Contact Number: |
| Email Address: |
| Doctor’s Name: |

Please complete the following details for who to contact in the event of an emergency:

**Emergency Contact (Next of Kin)**

|  |
| --- |
| Name: Telephone Number: |
| Address: Relationship to you: |

Please complete the following set of questions about Covid-19 and your general health which will help us to treat you safely and offer you the best care. If you do have any questions, please feel free to discuss these with your dentist.

Please indicate YES/NO to the following

**Covid-19 Questionnaire** Yes/No

|  |  |  |
| --- | --- | --- |
| Have you tested positive for COVID-19 in the last 7 days? |  |  |
| Are you waiting for a COVID 19 test or the results? |  |  |
| Do you have any of the following symptoms?   1. New, continuous cough 2. High temperature of fever 3. Loss of or change in sense of smell or taste |  |  |
| Do you live with someone who has either tested positive for COVID-19 or has had symptoms of COVID-19 in the last 14 days? |  |  |
| Have you been notified by NHS Test and Trace in the last 14 days that you are a contact of a person who has tested positive for COVID-19 and you do not live with that person? |  |  |
| Are you vulnerable or shielded patient (Please see below categories of vulnerable patients) |  |  |

**General Health Questionnaire** Yes/No

|  |  |  |
| --- | --- | --- |
| Do you drink alcohol? If yes, please detail weekly unit consumption.  (1/2 pint beer/lager = 1 unit. 1 small glass of wine = 1 unit) |  |  |
| Do you smoke? If yes, please detail your average daily amount. |  |  |
| Are you an expectant or nursing mother? |  |  |
| Have you been treated with any hydrocortisone or corticosteroids? |  |  |
| Do you carry a medical warning card? |  |  |
| Do you have or have you ever had any of the following: |  |  |
| 1. Rheumatic fever |  |  |
| 1. Heart complaints, heart surgery or stroke? Please detail below. |  |  |
| 1. Excessive bleeding? |  |  |
| 1. Blood borne virus? (Hepatitis/HIV) please tick OR TELL THE DENTIST |  |  |
| 1. High blood pressure? |  |  |
| 1. Diabetes? |  |  |
| 1. Epilepsy or fainting attacks? |  |  |
| 1. Chronic bronchitis or asthma? |  |  |
| 1. Arthritis? |  |  |
| Do you have any other serious condition? Please detail. |  |  |
| Are you allergic to any medicines, tablets, substance, latex or other? Please detail. |  |  |
| In the past two years, have you undergone any operations? Please detail. |  |  |
| Are you attending or receiving treatment from a doctor, hospital, clinic or specialist? |  |  |
| Are you currently taking any medicine or tablets? Please list ALL current medication and dose below. |  |  |

Completed by: (delete as appropriate) Self Parent/Guardian

Print Name:

Electronic Signature (if applicable):

Date:

**Vulnerable/Shielded Patient Category:**

Patients who are shielded or are vulnerable and those who are at most significant risk from COVID-19

● aged 70 or older (regardless of medical conditions)

● under 70 with an underlying health condition listed below (i.e. anyone instructed to get a flu jab as an adult each year on medical grounds):

* chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis
* chronic heart disease, such as heart failure
* chronic kidney disease
* chronic liver disease, such as hepatitis
* chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy
* diabetes
* problems with your spleen – for example, sickle cell disease or if you have had your spleen removed
* a weakened immune system as the result of conditions such as HIV and AIDS, or medicines such as steroid tablets or chemotherapy
* being overweight (a body mass index (BMI) of 40 or above)

● those who are pregnant