Carlton Dental Practice, 1 Carlton Rd S, Weymouth
DT4 7PL, Tel:01305 784036

**Patient Name** **D.O.B.**

**Address** **Telephone No.**

**Email** **Patient No.**

**Sex** **Hygienist**

**Last Medical Exam at Surgery** **Dentist**

**GP Details**

Medical Questions on File

| **Medical Questions** | **Tick if Yes** | **Notes** |
|---|---|---|
| Have you been tested positive for Covid-19 in the last 14 days? | ☐ | |
| Have you had any Covid-19 symptoms in the last 14 days (temperature over 37.8, continous cough, loss of smell or taste)? | ☐ | |
| Have you or any member of your household have been advised to self-isolate? | ☐ | |
| Are you attending or receiving treatment from a Doctor, Hospital or Clinic? | ☐ | |
| Are you taking any medicines from your doctor (tablets, creams, ointments, injections, other) | ☐ | |
| Are you taking or have you taken steroids in the last 2 years? | ☐ | |
| Are you allergic to any medicines, food or materials? | ☐ | |
| Have you had Rheumatic Fever or Cholera (ST VITUS DANCE)? | ☐ | |
| Have you had Jaundice, Liver, Kidney Disease or Hepatitis? | ☐ | |
| Have you ever been told you have a heart murmur, heart problems, angina, blood pressure or heart attack? | ☐ | |
| Have you had any blood tests, inoculations, etc? | ☐ | |
| Have you had your blood refused by the blood transfusion service? | ☐ | |
| Have you had a bad reaction to general or local anaesthetic? | ☐ | |
| Have you had a joint replacement? | ☐ | |
| Have you been hospitalised? If "YES", what for and when? | ☐ | |
| Do you have arthritis? | ☐ | |
| Do you have a pacemaker, or any form of heart surgery? | ☐ | |
| Do you suffer from hay fever, eczema or any other allergy? | ☐ | |
| Do you suffer with bronchitis, asthma or any other chest conditions? | ☐ | |
| Do you have fainting attacks, giddiness, blackouts or epilepsy? | ☐ | |
| Do you have diabetes or does anyone in your family? | ☐ | |
| Do you bruise easily or following a tooth extraction, surgery or injury, have you or your family bled so as to cause you to be worried, bleeding disorders? | ☐ | |
| Do you carry a warning card? | ☐ | |
| Do you ever get cold sores? | ☐ | |
| Do you smoke (or have you done so in the past)? If so how many tobacco products do you use per day/week? | ☐ | |
| Do you drink alcohol? If yes then how many units per week do you consume? | ☐ | |
| Do you chew tobacco pan or use supari currently (or have done so in the past)? | ☐ | |
| Do you have or are you being treated for Cancer, HIV/AIDS? | ☐ | |
| Do you suffer from any infectious diseases including tuberculosis? | ☐ | |
| Are you taking warfarin or a blood thinning medication? | ☐ | |
| Are you pregnant? | ☐ | |
| Are there any other aspects concerning your health that you think the dentist should know about such as self prescribing medicines (for example aspirin)? | ☐ | |

If you are not sure of any of the questions, or if your medical circumstances change, please inform the Dental Surgeon

Date: Patient Signature:



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