Phoenix Dental, 86 Portland Road, Weymouth
DT4 9AB, Tel:01305774370

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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