**Boston House Dental Clinic**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mr | Mrs | Ms | | Miss | Dr |  | First Name |  | | Surname |  |
| Your Address | | |  | | | | | | | Postcode |  |
| Your Number | | |  | | | | | | Date of Birth | |  |
| Your E-mail | | |  | | | | | | Occupation | |  |

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| **GENERAL MEDICAL QUESTIONAIRE** | | | | |
| **Please tick as appropriate:** | | **yes** | **no** | **details** |
| Have you had any symptoms associated with Covid-19 in the past 7 days? | |  |  |  |
| Are you having any medical treatment at the moment? | |  |  |  |
| Are you taking any medicines, drugs or pills? | |  |  |  |
| specifically: steroids (now, or in the past)? | |  |  |  |
| anti-coagulants? | |  |  |  |
| bisphosphonates? | |  |  |  |
| Are you pregnant? | |  |  |  |
| Had rheumatic fever? | |  |  |  |
| Had any major operations or illnesses? | |  |  |  |
| Had any form of hepatitis? | |  |  |  |
| Had positive blood test results for HIV? | |  |  |  |
| Reacted to local or general anaesthesia? | |  |  |  |
| Had a hip or other joint replacement? | |  |  |  |
| Do you drink alcohol? (how may units per day?) | |  |  |  |
| Do you smoke? (how many per day?) | |  |  |  |
| Do you have a pacemaker? | |  |  |  |
| Do you have any allergies? | penicillin |  |  |  |
| latex |  |  |
| iodine |  |  |
| other |  |  |
| Do you have asthma? | |  |  |  |
| Do you have epilepsy? | |  |  |  |
| Do you get cold sores? | |  |  |  |
| Do you have diabetes? (does a family member?) | |  |  |  |
| **Do you now, or have you ever, had problems with:** | |  |  |  |
| Your heart? | |  |  |  |
| Your blood pressure? | |  |  |  |
| Your lungs or chest? | |  |  |  |
| Your liver or kidneys? | |  |  |  |
| Fainting? | |  |  |  |
| **Are there any other health related issues we should know about?** | |  |  |  |

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| for a child, the parent’s/guardian’s name(s): |
| Your medical doctor’s name and address: |
| How did you hear about us? |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Do you have Dental Insurance cover?** | Cigna | Denplan | Bupa | Aviva | DPN | Unum | Other | None |

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| **Patient Signature**: **Date:** **Dentist Signature: Date:** |