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|  |  |  |
| --- | --- | --- |
| Title | Name | Surname |
|  |  |  |
| Gender | Date Of Birth | NHS Number |
|  |  |  |
| Tel Home | Tel Mobile | Tel Work |
|  |  |  |
| Address |
|  |
| Email (REQUIRED) |
|  |
| Occupation | GP Name and Address |
|  |  |
| I am happy to receive/ communication Text/Email/Letter | Patients under **16** - Parental responsibility (Both parents),If not please state who has parental responsibility below |
|  |  |
| Emergency contact Person | Phone Number | Relationship to me |
|  |  |  |

 Continue overleaf.

|  |  |  |  |
| --- | --- | --- | --- |
| CURRENT CONDITIONS & ALLERGIES | Yes | No | Unsure |
| Are you carrying a medical warning card?  |  |  |  |
| Are you receiving treatment from a doctor, hospital or clinic? |  |  |  |
| Are you pregnant?  |  |  |  |
| Are you allergic to any medicines (e.g., Penicillin), general or local anaesthetics, substances (e.g., latex/rubber), or foods? |  |  |  |
| Do you suffer from hay fever, any skin diseases or eczema? |  |  |  |
| MEDICINES & TREATMENTS |  |  |  |
| Are you taking any (self-) prescribed medicines (e.g., tablets, ointments, injections, inhalers, eyedrops, suppositories, nebulisers, the contraceptive pill or HRT)? |  |  |  |
| Have you ever had a steroid treatment? |  |  |  |
| DO YOU SUFFER FROM |  |  |  |
| Any heart problems, angina, heart murmur, high blood pressure or have you ever had a stroke? |  |  |  |
| Bruising or persistent bleeding following injury, surgery or tooth extraction? |  |  |  |
| Bronchitis, asthma or any other chest condition? |  |  |  |
| Any infectious diseases (e.g., HIV, hepatitis, TB)? |  |  |  |
| Diabetes?  |  |  |  |
| Kidney or liver diseases (e.g., jaundice, hepatitis)? |  |  |  |
| Neurological / nerve diseases (e.g., neuropathy, MS, chorea) or fainting attacks, giddiness or epilepsy? |  |  |  |
| Arthritis or rheumatic fever? |  |  |  |
| Muscle problems (e.g., myopathy, dystrophy, paralysis)?  |  |  |  |
| Stomach, ulcers, hiatus hernia, or indigestion? |  |  |  |
| Any other serious illnesses? |  |  |  |
| SURGICAL & HOSPITAL STAYS |  |  |  |
| Have you ever had a heart or brain surgery? |  |  |  |
| Have you had a joint replacement or any other implant? |  |  |  |
| Have you ever been treated in a hospital? |  |  |  |
| FAMILY HISTORY |  |  |  |
| Does anyone in your family have diabetes?  |  |  |  |
| Has anyone in your family ever suffered from cancer? |  |  |  |
| DRINKING, SMOKING & CHEWING |  |  |  |
| How many units of alcohol do you drink per week? (1 unit = half pint of lager or one shot of spirits or a single glass of wine/aperitif) |  |
| Do you smoke or chew tobacco products now? Or did you in the past?  |  |
| If so please state how many per day |  |
| Do use Vape/e-cigarettes? |  |

Continue overleaf.

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| Please list any additional details to the previous questions: |
|  |
| Please list any self-prescribed medication (e.g., aspirin) |
|  |
| Please list any medication prescribed by your doctor (REQUIRED) |
|  |

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| VISITS TO YOUR DENTIST |
| How do you feel when visiting a dentist?  | Anxious | Nervous | Relaxed |
| When did you last visit a dentist?  |  |
| Are there any dental procedures, which have frightened you in the past, or which make you nervous? |  |
| Are there any cosmetic treatments you have considered? |  |

|  |  |
| --- | --- |
| I confirm that I have read the above and filled in this form to the best of my ability. |  |
| Completed By (Type in Box) *Self/Parent/Guardian/Dentist* |  |
| Signed (Type Name Below) | **Date** |
|  |  |