Medical History

We would be grateful if you would fill in the questionnaire below and return it to the practice either prior to your appointment, electronically (edit and return via email) or in person when you attend for your appointment.

Name & Title: ..... **D.O.B.** .....

Mobile number: ..... **Email:** .....

Address: .....

..... **Postcode:** .....

GP Name and Address: .....

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Please Give Details if Any of these Answers Are Yes

Covid History	Yes	No	
Have you had a covid-19 vaccine?	☐	☐	If yes, number of vaccines:
Are you displaying symptoms of a respiratory infection, such as COVID-19, have a high temperature and/or you do not feel well enough to go to work or carry out normal activities?	☐	☐	If yes, please ring the practice on 01904 798315 for advice
Are you currently…..	**Yes**	**No**	**Give Details**
Receiving treatment from a doctor, hospital or clinic?	☐	☐	
Are you undergoing or have you had previous treatment for any cancers? (If yes, please give details).	☐	☐	
Taking any prescribed medicines (tablets, ointments, injections, inhalers, including contraception and hormone replacement therapy)?	☐	☐	
Pregnant or possibly pregnant?	☐	☐	
Carrying a medical warning card?	☐	☐	
Have you ever suffered from…	**Yes**	**No**	**Give Details**
Allergies to any medications (e.g. penicillin) or substances (latex/rubber) acrylic nails or foods?	☐	☐	
Bronchitis, asthma or other chest conditions?	☐	☐	

Have you ever suffered from… *(continued)*	Yes	No	Give Details
Fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Heart problems, angina, blood pressure problems or stroke?	☐	☐	
Diabetes? (or does anyone in your family)	☐	☐	
Bone or joint disease?	☐	☐	
Bruising or persistent bleeding following injury, tooth extraction or surgery?	☐	☐	
Liver disease (e.g. jaundice/hepatitis) or kidney disease?	☐	☐	
Any infectious diseases (including HIV and hepatitis)?	☐	☐	
A condition that led to your blood being refused by Blood Transfusion Service?	☐	☐	

Did you, as a child or since, ever have…	Yes	No	Give Details
A bad reaction to general or local anaesthetic?	☐	☐	
Treatment that required you to be in hospital?	☐	☐	
Brain surgery?	☐	☐	
Heart surgery?	☐	☐	

Alcohol		
How many units of alcohol do you drink per week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif)?		units per week

Tobacco use	Yes	No	In the past	Times per day
Do you smoke any tobacco products (or have you in the past)?	☐	☐		

Please give further or any other details which your dentist might need to know about, such as self-prescribed medicines (eg. aspirin).

I consent to the use and storage of my personal data in accordance with the Beeches Dental Practice Privacy Notice (if you wish to see a copy of our privacy notice please let us know). I declare that all the answers to the above questions and information are true to the best of my knowledge.

Signed: ..... **Date:** .....

Pre-Appointment Consent

I .....

consent to being seen at Beeches Dental Practice on / / where I will be offered appropriate advice and treatment with regards to my dental health. I will verbally agree to any treatment at the appointment after I have understood the explanation of the reason for the treatment, the pros and cons, and the alternative treatments if available.

Please sign here

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***To be signed and to be returned to the practice with the above documents in advance of the pre-arranged appointment. The original and an electronic copy will be placed in your dental notes. If you wish for a copy please ask.**