St Mellion Dental Clinic Patient Medical Questionnaire

We ask you for information about your general health to help us treat you safely.
Please ensure all questions on both pages have a response – a NO is just as important as a YES!
We take great care with all the Personal Data we hold, to ensure we comply with best professional practice and with the law. For a full copy of our Data Privacy Notice please ask at reception or ask any member of staff.

TITLE: **FORENAME(S):**

SURNAME: **DATE OF BIRTH:**

ADDRESS:

POSTCODE:

Telephone; Home: **Work:**

Mobile: **E-mail:**

Occupation:

	YES	NO
I give my permission for my personal data to be stored in compliance with the data protection act May 2018	☐	☐
I give my permission to receive **e-mail** relating to my ongoing care and treatment if those contact details are provided	☐	☐
I give my permission to receive **SMS messages** relating to my ongoing care and treatment if those contact details are provided	☐	☐
I give my permission to receive **letters** relating to my ongoing care and treatment if those contact details are provided	☐	☐

Children under 18 are seen as NHS patients **if** we have their **NHS number**

Please give their NHS number here:

I understand that it is my responsibility to inform the clinic of any changes to the information given on this form.

Signed: **Date:**

PLEASE TURN OVER

ARE YOU CURRENTLY:	**NO**	**YES**	**FULL DETAILS**
Receiving treatment from a doctor, hospital or clinic?			
Taking any prescribed medicines (e.g. tablets, ointments, injections or inhalers, including HRT and contraceptives)?			*Names of medicines (attach separate sheet if necessary)*
Carrying a Medical Warning Card or other MediAlert device?			

DO YOU SUFFER FROM:	**NO**	**YES**	**FULL DETAILS**
Allergies to any medicines (e.g. Penicillin), substances (e.g. Latex) or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest condition?			
Fainting attacks, giddiness, blackouts or epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Osteoporosis or bone tumours?			
Diabetes?			
Arthritis			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases (including HIV or Hepatitis?)			
Cold sores?			
Dementia?			

DID YOU, AS A CHILD OR SINCE, HAVE:	**NO**	**YES**	**FULL DETAILS**
Liver disease (e.g. jaundice or hepatitis) or kidney disease?			
Any other serious illness?			
A bad reaction to a general or local anaesthetic?			
A joint replacement or other implant?			
Treatment that required you to be in hospital?			
Heart surgery			
Brain surgery?			
Have you received at least two doses of the COVID vaccination?			

	NO, I HAVE NEVER USED	**I HAVE USED IN THE PAST**	**YES, I USE NOW**	**QUANTITY PER DAY**
SMOKING: Do you smoke or use any tobacco products (including e-cigarettes) now (or have you in the past)?				

Are you taking any blood-thinning medication such as **Warfarin, Aspirin** or **Clopidogrel, Dabigratran?** Please specify and give your most recent INR if applicable.

Women only: Are you pregnant? (Please give due date) or have you had a baby within the last 12 months? (Please give date of delivery).

Pregnant: Due Date:

Baby born in last 12 months: Date of delivery:

NAME AND ADDRESS OF YOUR MEDICAL DOCTOR:

Dr: **Surgery/Clinic/Health Centre**

FORM COMPLETED BY: **SELF** **PARENT** **GUARDIAN**

SIGNATURE **DATE**