Medical and Dental Questionnaire

In the interests of **your safety** and to provide the most appropriate dental care for your needs we kindly ask you to complete this Medical and Dental Questionnaire and email it to **info@rddental.co.uk** at least 48 hours before your appointment. The form should take no longer than 15 minutes to complete. We thank you in advance for your time taken to complete this form.

Please rest assured this data will be stored securely in your records and for future appointments you will be able to edit the data and not need to re-enter it all. Alternatively you can save the completed form to your device such that for future appointments you can easily update any changes.

If you have any difficulties/concerns with completing the questionnaire please call 01162779853 and one of our team will be able to help you.

Title		**Full Name**	
Date of Birth	☐☐/☐☐/☐☐	**Address**	
Postcode		**Email**	
Tel: Home		**Tel: Mobile**	
Doctors Name and Address			

	Yes	No	Please give details if 'Yes'
Are you receiving treatment from a doctor, hospital or clinic?	☐	☐	
Do you take any prescribed medicines/ Have you taken any prescribed medicines in the last two years?	☐	☐	
Do you carry a medical warning card?	☐	☐	
Have you received any chemotherapy or radiotherapy?	☐	☐	
Do you have any allergies to any medicines, materials or food?	☐	☐	
Do you suffer from bronchitis, asthma, or other chest condition?	☐	☐	
Have/Do you suffer from fainting attacks, giddiness, blackouts, epilepsy?	☐	☐	
Have/Do you suffer from heart problems, angina, blood pressure problems, or stroke?	☐	☐	
Do you or anyone in your family suffer from Diabetes?	☐	☐	

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	Yes	No	Please give details if 'Yes'
Do you suffer from any digestive problems (stomach,bowel)?			
Do you suffer from any problems with your bones or joints (Arthritis, osteoporosis, etc)?			
Have you ever had bruising or persistent bleeding following injury, tooth extraction or surgery?			
Do you suffer from liver disease (jaundice,hepatitis, etc) or kidney disease?			
Is there any other serious illness or infectious disease your dentist needs to know about?			
Has your blood ever been refused by The Blood Transfusion Service?			
Have you ever had bad reaction to general or local anaesthetic?			
Have you ever had treatment that required you to be in hospital (any form or surgery, any need to be admitted as an in-patient)?			
Are you pregnant or breastfeeding?			
How many units of alcohol do you drink per week (1 unit = half of a standard glass of wine/rose, One third of a pint of beer or a single spirit measure?			
Do you smoke tobacco products now (or have you in the past)? If yes how many a day and for how long?			
Do you chew tobacco, pan, use gutka, or supari (or have you in the past)?			
Do you use a fluoride toothpaste? (if unsure please give details of the toothpaste you use)			
Are you aware if you grind or clench your teeth?			
Do you add sugar to hot drinks? If so how many times a day do you drink hot drinks?			
Do you drink fizzy/sport/energy drinks (including diet fizzy drinks)? If so how frequently?			
Do you drink squash/juice daily? If so how many times a day?			

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	Yes	No	Please give details if 'Yes'
Do you have sugary snacks or drinks between meals?	☐	☐	
Do you have sugary snacks or drinks before bedtime?	☐	☐	
Do you suffer from Anxiety when it comes to attending the dentist?	☐	☐	
Is there anything else we need to be aware of in terms of your medical history?			
Emergency Contact Name			
Emergency Contact Number			

I consent to my General Medical Practitioner being contacted for further medical information if and when required. I consent to photographs and x-rays being taken as required for my clinical records only, unless otherwise specified my dentist.

Dental Questionnaire

	Yes	No	Please give details if 'Yes'
Are you suffering from Dental Pain/Swelling? If so please also provide details of any medication you have taken?	☐	☐	
Do you suffer from Bad Breath?	☐	☐	
Are any of your teeth sensitive?	☐	☐	
Are any of your teeth mobile/wobbly/drifting?	☐	☐	
Do your gums bleed or are they sore?	☐	☐	
Do you have any missing teeth that are of concern?	☐	☐	
Are you able to eat/chew comfortably and confidently?	☐	☐	
Do you suffer from clicking/locking/pain around your jaw joints?	☐	☐	
Do you have a tendency to gag during dental procedures?	☐	☐	
Are you happy with the appearance of your teeth (size/shape/colour)?	☐	☐	

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Do you participate in contact sport that requires a gum shield?	☐	☐	
Do you have any other concerns about your dental/oral health?	☐	☐	

How did you hear about us?

How did you hear about RD Dental? required

- ☐ Already a patient
- ☐ Referral by own dental surgeon
- ☐ Personal recommendation by friend or family
- ☐ Internet search
- ☐ Referral by other healthcare professional
- ☐ Walking by
- ☐ Local newspaper/magazine

Name of friend/family member/healthcare professional who referred you (if applicable)

Please continune to the Covid-19 Questionnaire below.

COVID-19 Screening Questionnaire

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our staff and patients, we are conducting a simple screening questionnaire. Your participation is important to help us take the necessary precautionary measures to protect you and everyone who enters this building. Thank you for your time.

Self-Declaration by Patient

1.	Have you tested positive for Covid -19 in the last 14 days or have you been in contact with anyone who has been diagnosed with Coronavirus or has exhibited any flu like symptoms or who has had to self-isolate in the last 14 days (including if you have been told this via NHS Test and Trace) ? **Yes** ◯ **No** ☐
2.	Are you waiting for a Covid-19 test or the results? **Yes** ◯ **No** ☐
3.	Have you experienced any cold or flu-like symptoms in the last 14 days including: Do you have a new continuous cough (1 hour recurrently or 3+ episodes in 24 hours)? **Yes** ◯ **No** ☐ Have you become breathless, or are you more breathless than usual? Do you struggle to breathe? **Yes** ◯ **No** ☐ Do you have a high temperature (fever)? If you don't have a thermometer do you feel hot to touch on your chest or back? **Yes** ◯ **No** ☐ A sore throat, a tacky throat or soreness when swallowing food? **Yes** ◯ **No** ☐ Have you experienced loss of taste and smell? **Yes** ◯ **No** ☐ Are you too ill to do your usual daily activities? **Yes** ◯ **No** ☐ Are you feeling more confused than normal? **Yes** ◯ **No** ☐
4.	Are you 70 OR OLDER? **Yes** ◯ **No** ☐
5.	Do any of the following apply to you: Are you pregnant? **Yes** ◯ **No** ☐ Do you suffer from any respiratory/lung diseases (COPD/emphysema/cystic fibrosis/asthma/bronchitis)? **Yes** ◯ **No** ☐ Do you suffer from Heart disease? **Yes** ◯ **No** ☐

COVID-19 Screening Questionnaire

5.	Are you Diabetic? **Yes** ◯ **No** ☐ Do you suffer from chronic kidney disease or liver disease? **Yes** ◯ **No** ☐ Do you suffer from any conditions affecting the brain or nerves (such as Parkinson's, motor neurone disease, multiple sclerosis, a learning disability or cerebral palsy)? **Yes** ◯ **No** ☐ Problems with your spleen (sickle cell disease or spleen removed)? **Yes** ◯ **No** ☐ Do you have a weakened immune system as the result of an autoimmune condition, HIV/AIDS, or medicines such as steroid tablets/ immunosppresants or chemotherapy? **Yes** ◯ **No** ☐ A Body Mass Index of 40 or above? **Yes** ◯ **No** ☐ Received an Organ Transplant? **Yes** ◯ **No** ☐ Undergoing radiotherapy for lung cancer? **Yes** ◯ **No** ☐ Cancer of the blood or bone marrow? **Yes** ◯ **No** ☐ Receiving immunotherapy/chemotherapy or antibody treatment for cancer? **Yes** ◯ **No** ☐ Receiving any other cancer treatments? **Yes** ◯ **No** ☐ Received a bone marrow or stem cell transplant in the last 6 months? **Yes** ◯ **No** ☐ Inherited an inborn error of metabolism that increases your risk of infections such as sickle cell disease? **Yes** ◯ **No** ☐
6.	Have you been advised that you need to be shielded or are at high risk (clinically extremely vulnerable) from coronavirus? **Yes** ◯ **No** ☐
7.	Do you live with someone who is at high risk (clinically extremely vulnerable) from coronavirus? **Yes** ◯ **No** ☐

COVID-19 Screening Questionnaire

If the answer to any of these Covid screening questions is **Yes** your dentist will call you regarding your appointment.

If the answer to all of the questions is **No** we will be able to proceed with your appointment, but please call us if you have any of the above symptoms on the day of your appointment.

Please be advised that we may complete a temperature check when you arrive at the practice.

Completed by self ☐ /parent ◯ /guardian ◯ (if under 16 years old parent/guardian should ideally sign)

Signature (Initials if completing electronically) _____

Date ☐☐/☐☐/☐☐

Thank you for your co-operation, which enables us to treat you safely using the information you have kindly provided. This will be handled in the strictest confidence. At RD Dental we take great care with all personal data we hold, to ensure we comply with best practice and with the law. If you require any further information about how you Data is handled please ask your dentist.