Longwood house dental care – sent by email/ website download

Medical History and Covid19 status- Questionnaire
Please note all details are strictly confidential

REFFERRED BY: (HOW DID YOU HERE OFF US ?)

Name…………………………..…….…….. Address……………………………………….

Home Tel …………………………….….. Mobile…………………………………………

Date of Birth……………………………… E mail:

Are you a shielding patient Yes/ No – if yes – why?
Are you living with a shielded patient? Yes/ No – what is their condition ?
Have you have covid19 diagnosis? Yes /No if yes- when?

Do you have or have you ever suffered from

Penicillin/ drug allergy	Yes / No
Are you taking bisphosphonates/ other HRT medicines	Yes / No
Rheumatic fever	Yes / No
Any heart complaint, heart surgery or stroke	Yes / No
Diabetes	Yes / No
Epilepsy or fainting attacks	Yes / No
Chronic bronchitis or asthma	Yes / No
Hepatitis	Yes / No
Excessive Bleeding	Yes / No
High blood pressure	Yes / No
Any other serious illness	Yes / No
Do you carry a medical warning card	Yes / No
Are you allergic to any medicine, tablets or substances	Yes / No
At present are you taking any medicine or tablets	Yes / No
In the past 2 years have you undergone any operations	Yes / No
Have you been treated with hydro-cortisone or corticosteroids	Yes / No
Are you pregnant	Yes / No
Have you ever had a joint replacement operation	Yes / No
Do you have a close relative who has or has had CJD	Yes / No
Please tell your dentist if you are HIV positive	
What is your average weekly alcohol consumption	…………Units
If you smoke what is your average per week	…………
Do you suffer from regular Headaches Backaches facial pain	
Do you / your partner suffer from snoring	Yes / No
Are you unhappy with your smile?	Yes / No
Do you want straighter teeth?	Yes / No
Have you had or consider having Age Perfecting treatments?	Yes / No
Would you like whiter teeth?	Yes / No
Do you have dentures which you would like replaced with implants ?	Yes / No

Patients signature________________________________ Date:___________________________