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|  |  *Union Street* *Darwen* *BB3 0DA* *Phone: 01254 703020**Email: enquires@darwendental.co.uk* |

**CONFIDENTIAL PATIENT QUESTIONNAIRE (RECALL)**

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| --- | --- | --- |
|   |   |  |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1 Are you receiving any medical treatment the present time? Yes/No

 Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you been a patient in hospital since your last visit? Yes / No

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you taken any medicine tablets, capsules or drugs since your last visit? Yes / No

 Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Are you, or have you been, under the care of a doctor since your last visit? Yes / No

 Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Have you been diagnosed with any of the following since your last visit.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Rheumatic Fever |  | Epilepsy |
|  | Heart Trouble |  | Anaemia |
|  | High Blood Pressure |  | Diabetes |
|  | Asthma |  | Kidney Trouble |
|  | Arthritis |  | Gastric Problems |
|  | Hepatitis - Specify type A, B, C |  | Cold Sores |
|  | Bronchitis or Chest Problems |  | Depressive Illness |
|  | Severe Headaches |  | Drug Dependence |

7. Have you had any prosthetic surgery? (E.g. Heart Valve or Hip Replacement) since your last visit? Yes / No

 Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Woman, Are you pregnant? If so, how many months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

9. Are you HIV positive or are you at risk of HIV exposure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

10. Do you smoke? If so how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

11. Do you drink alcohol? If so how many units per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

**COVID-19 HEATLH QUESTIONAIRE**

• Do you or anyone in your household have COVID-19? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• Do you have a new, continuous cough? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• Do you have a high temperature (37.8oC or over)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• Do you have a loss of, or change in, your normal sense of taste or smell? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• Does anyone in your household have a new, continuous cough, or a high temperature, or a loss of, or change in, their normal sense of taste of smell? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• If you or anyone in your household has, or has had, possible or confirmed COVID-19, are you still in the self/household isolation period? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

If you have answered ‘no’ to all of the above, do you belong to any of the groups below:

• patients who are shielded – those at the highest risk of severe illness from COVID-19 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• patients who are at increased risk of severe illness from COVID-19 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

• patients who do not fit one of the above categories \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes/No

**Signed:** Patient/Parent/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_