#

# Current state of health questionnaire

**It is vitally important that you fill in this questionnaire no more than 3 days before your appointment at the practice to ensure it is as up to date as possible.**

* **Have you been in contact with someone who may have COVID-19 or had any of the following recently? (within the last 14 days)**

 I have been in contact but I am asymptomatic Yes/No

*\*if yes, have you been tested Yes/No*

*\*if yes, what where the results Positive/Negative*

Persistent cough Yes/No

Shortness of breath or difficulty breathing Yes/No

Any symptoms of respiratory illness Yes/No

Temperature above 37.8 degrees Yes/No

* **Based on your activity over the last 4 weeks, how would you subjectively classify your risk of being exposed to or infected by COVID-19? (tick as appropriate)**

High risk – frontline health care worker or confirmed case of infection at home

Moderate risk – key worker in contact with public but without symptoms or known exposure to an infected individual

Low risk- have been isolated/in lockdown alone or with family members with minimal social contact and no known exposure to an infected individual

Previously infected and recovered – confirmed by hospital testing with documentation (please bring documentation with you when attending)

**If you have been in contact with somebody with confirmed Covid-19 and have not had a test, we will not be able to treat you at the practice until you have been tested negative.**

* **Are you in one of the following groups, which have been identified as being at higher risk of serious complications should they contract Covid-19.**
* BAME
* Over 75
* Pre-existing medical condition

**Medical History checked verbally with patient and updated on R4**

**Patient risk assessed as ………………….**

**Assigned to patient Group………………**

**Outcome**

1. **Appointment made at Practice**
2. **Remote advice given**
3. **Referred to UDC**
4. **Advised to remain shielded, but to call back if problem worsens**
5. **Dentist to call to discuss**

**Patient disclaimer**

I, understand that by attending the Practice I may be at an increased risk of contracting Covid-19. I accept these risks and have decided, after discussion with the Practice that the benefit to me of attending for my dental appointment, outweighs any potential risk of contracting Covid-19.

Print Name…………………………………………..

Signature…………………………………………….

Date…………………………………………………….