# Date: Time: Name: Address:

Postcode: NHS number (if known)

# Name of parent or

carer (if applicable)

# Patient’s GP Practice and Contact Number:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | PRE- APPOINTMENT | | ON SITE | |
| Date: |  | |  | |
| Called previously for AAA? If so insert date and advice given here: | Yes | No | Yes | No |
| Have you been diagnosed with Coronavirus? | Yes | No | Yes | No |
| Are you having shortness of breath or other difficulties breathing? | Yes | No | Yes | No |
| Do you currently have a cough? or have you had a persistent dry cough in the last 14 days? | Yes | No | Yes | No |
| Any other flu-like symptoms, such as gastrointestinal upset, headache  or fatigue? | Yes | No | Yes | No |
| Have you experienced recent loss of taste or smell? | Yes | No | Yes | No |
| Are you in contact with any confirmed COVID-19 positive patients?  Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment. | Yes | No | Yes | No |
| Are you 70 years old or above? | Yes | No | Yes | No |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-  immune disorders? | Yes | No | Yes | No |
| Have you travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location) | Yes | No | Yes | No |

**Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.**

*Please turn over*

Medical history (including allergies, and medication)

Presenting complaint

History of presenting complaint and/or previous treatment:

## PAIN

Where is the pain coming from? How long has pain been there? Severity scale: 1 (no pain) - 10 (worst pain ever)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Constant pain / does it come and go? Has it kept you awake / does it get worse at night?

## SWELLING

Have you taken any painkillers?

Yes No

Intraoral swelling? Size/duration Extraoral swelling? Size/duration Functional impairment caused by swelling (swallowing, breathing and trismus)

## BLEEDING

Source, duration, amount? Recent extractions? Previous bleeding problems (ask about anticoagulant medications/conditions)

## TRAUMA

How, Where, What, When?

Any loss of consciousness – have they visited A&E?

## OTHER

Ulcers – location, size, duration? Orthodontic appliances – is it causing soft tissue trauma? Additional notes (including any mobility or communication needs)