Medical Health Screening Form for Dental Treatment

Objectives : For health evaluation in patients undergoing dental treatments providing safety to patients and related parties. The decision to perform dental treatment is subject to additional history taking and the dentist's discretion.

Name ....Age ....years
Medical conditions / Allergies / Pregnancy...
Occupation (Please specify)...Telephone No.........................

Please provide the following information by checking / in ☐

1. Do you have any of the following conditions? (within the past 14 days)	**Yes**	**No**
1.1 History of contacting or close contact with COVID-19 patient....................	☐	☐
1.2 History of a involving cluster infection /highly controlled area	☐	☐
1.3 History of travelling abroad /province (Please specify)...............................	☐	☐
1.4 History of visiting public places or attending large gatherings....................	☐	☐

2. Do you have any of the following symptoms?	**Yes**	**No**
2.1 Fever..	☐	☐
2.2 Cough..	☐	☐
2.3 Runny nose..	☐	☐
2.4 Sore throat..	☐	☐
2.5 Difficult breathing/Shortness of breath..	☐	☐
2.6 Altered/poor smell...	☐	☐
2.7 Altered/poor taste	☐	☐
3. History of being confirmed with COVID-19 infection but recovered (Please specify the date of recovery..........................)	☐	☐

4. Documented temperature ....Degrees celsius

I hereby certify that the information given on this form is accurate. Therefore, I have given my signature as a confirmation.

Signature of Patient/Legal Guardian..............................

(..)

Signature of Examiner ....

(..)

Date.......................................Entry time............................Exit time...........................

**** If you have a history of a confirmed COVID-19 infection, but have recovered and undergone home isolation for 1 month, you may receive treatment.**

(In emergency/urgency case the dentist will provide appropriate procedures)
COMMUNICABLE DISEASES ACT, B.E.2558 (2015)

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