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| Pt Reference Number: | |
|----------------------|--|

Confidential Medical History & COMMS Consent form

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|---|------------------|-----------|---------|----------|------------|
| First Name: | | Surname: | | | |
| Date of birth: | | Tel: | | | |
| Address | | | | | |
| Email | | | | | |
| Are you happy to be contact for reminders? | | | YES | NO | |
| From time to time we may contact you with details of promotions/services we provide. Please tick yes/no to confirm if you are happy for us to do so | | | YES | NO | |
| How did you hear about this TFC? Please tick | | | | | |
| Website | Family or friend | Instagram | Twitter | facebook | Other..... |

PLEASE ANSWER ALL OF THE QUESTIONS with x

| | YES | NO | | YES | NO |
|---|-----|----|---|-----|----|
| Are you seeing a doctor for any reason? | | | Liver/ kidney disease? | | |
| Do you or family have Diabetes? | | | Asthmatic? | | |
| Are you Carrying any warning cards | | | Do you have a high sugar/acid intake? | | |
| HIV/hepatitis? | | | Have you had brain surgery | | |
| High or low blood pressure | | | Mental health diagnosis? | | |
| Do you suffer with angina | | | Do your gums bleed? | | |
| Did you have a stroke | | | Pregnant? | | |
| Have you had heart surgery | | | Do you drink alcohol? Units..... | | |
| Normal bleeding after cutting or tooth removal? | | | Problems with local or general anaesthetic? | | |
| Do you smoke? | | | Any other illnesses not listed above | | |
| If yes how many? | | | | | |
| Do you want to quit? | | | | | |

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| Please note down any medications you are currently taking: | Please list any allergies: |
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| GP details - |
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|------------|-------|
| Signature: | Date: |
|------------|-------|