United Dentacare

HEALTH STATEMENT

Name_____ Date of Birth_____

Information contained within this document is governed by the data protection Act 1998. Disclosure of information is only with your informed written consent. The information is assessed by United Medicare, who will advise on your fitness to practise. Please ensure the health statement is completed fully.

Your GP Name_____

Address_____

_____ Telephone No_____

NHS OR OTHER SCREENING HISTORY

Name of Trust or hospital which gave your most recent screening:_____

Date of most recent screening:_____ **Where the results in any way abnormal?** Yes ☐ No ☐

(If the results abnormal, please provide details in the space provided below)

BASIC HEALTH HISTORY

If your answer to any of these question is YES, OR If you are currently taking any medications, please give details in the space provided below:

Is there any aspect of your health which may restrict your ability to work as a dentist?	Yes ☐	No ☐
Are you currently, or regularly taking, any medicines, tablets, special clients or injections?	Yes ☐	No ☐
Is there any aspect of your medical history about which an employer should or might wish to know?	Yes ☐	No ☐
Would you require any adjustments to the working environment to work as a doctor?	Yes ☐	No ☐
Do you have any conditions of vision, hearing or speech which might effect your ability to work as a doctor?	Yes ☐	No ☐
Have you ever suffered from any mental illness / depression or alcoholism or drug dependency?	Yes ☐	No ☐
Are you attending any hospital for treatment, or are you on a waiting list for hospital treatment?	Yes ☐	No ☐

Do you now, or have you ever, suffered from or received treatment for:

a)	Respiratory (including asthmatic or allergic) symptoms, disorders or diseases?	Yes ☐	No ☐
b)	Cardiovascular symptoms, disorders or diseases?	Yes ☐	No ☐
c)	Gastrointestinal symptoms, disorders or diseases?	Yes ☐	No ☐
d)	Neurological (including epileptic) symptoms, disorders or diseases?	Yes ☐	No ☐
e)	Psychiatric symptoms, disorders or diseases?	Yes ☐	No ☐
f)	Genitourinary symptoms, disorders or diseases?	Yes ☐	No ☐
g)	Skin symptoms, disorders or diseases, including reaction to gloves / glove powder?	Yes ☐	No ☐
h)	Endocrine (including diabetic) symptoms, disorders or diseases?	Yes ☐	No ☐
i)	Haematological symptoms, disorders or diseases?	Yes ☐	No ☐
j)	Recurrent sore throat (including any treatment required for MRSA infection)?	Yes ☐	No ☐
k)	Bone or joint symptoms, disorders or diseases (including back pain)?	Yes ☐	No ☐
l)	Immuno-deficiency symptoms, disorders or diseases?	Yes ☐	No ☐
m)	Stress related symptoms, disorders or diseases?	Yes ☐	No ☐
n)	Alcohol / drug related symptoms, disorders or diseases?	Yes ☐	No ☐
o)	Overseas travel related symptoms, disorders or diseases?	Yes ☐	No ☐
p)	Contact with MRSA?	Yes ☐	No ☐

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IMMUNISATION HISTORY

Have you had any of the following illnesses / diseases?	Please indicate YES or NO and give date			
Rubella (German Measles)*	Yes ☐	No ☐	Date_____	
Varicella (Chicken Pox)*	Yes ☐	No ☐	Date_____	
Measles	Yes ☐	No ☐	Date_____	
Hepatitis C	Yes ☐	No ☐	Date_____	
Do you have a visible BCG scar of at least 4mm diameter?*	Yes ☐	No ☐		
Have you had at least 2 Tetanus boosters since age 12?	Yes ☐	No ☐		
				Tick if immunisation took place in UK
Have you had a Tuberculosis test?	Yes ☐	No ☐	Date_____	☐
Heaf / Tine/ Mantoux (delete as appropriate)			Result_____	
Have you ever had any of the following immunisations?	Please indicate YES or No and give date			
Rubella (German Measles)*	Yes ☐	No ☐	Date_____	☐
Varicella (Chicken Pox)*	Yes ☐	No ☐	Date_____	☐
MMR (Mumps, Measles, Rubella)	Yes ☐	No ☐	Date_____	☐
Diphtheria	Yes ☐	No ☐	Date_____	☐
Poliomyelitis	Yes ☐	No ☐	Date_____	☐
Tetanus	Yes ☐	No ☐	Date_____	☐

Please provide written evidence to support above results

HEPATITIS B

You must provide a copy of the most recent actual UK Pathology Report showing titre level (>100Iu/l if possible) or antigen status if titre level < 100Iu/l.

You must also provide a printed Occupational Health / GP Immunisation including the following information:

Dates of primary course of Hepatitis B vaccine _____

Post-course titre levels _____

Dates of all subsequent booster doses _____

Please enter any additional information below. If there is insufficient room please continue on another sheet.

I declare that the information provided on this form is correct to the best of my knowledge.

Signed _____ Date _____