BRUNSWICK DENTAL
PRACTICE

Confidential
Medical Health History

In order to treat you safely, your dentist, therapist and hygienist must be aware of your full previous medical health history. Please complete this form carefully. ALL medical questions are relevant to your treatment here. Even if you aren't sure what the connection is please fill in as much as you can.
If you aren't sure, please ask your dentist. Information given is treated in the strictest confidence.

Your Contact Details

Title	
First Name(s)	Last Name
Known as-	
Date of Birth D D M M Y Y Y Y	
Address	
	Postcode
Daytime number	Evening number
Mobile number	Twitter account
Email address	

Where possible, please contact me by:

E mail ☐	Post ☐	Text message ☐

Occupation	Company name

How did you hear about us? Please tick all appropriate boxes

Recommendation ☐	Referral by dentist/doctor ☐	Online Search ☐	Website ☐
Yell ☐	Facebook ☐	Phone Book ☐	Other ☐

In an emergency please contact	
Name	Relationship to me
Mobile No.	Alternative Tel. No.
Are you insured for your dental care?	Name of Insurance Provider
Are you a Brunswick Member Patient? Y N ?	

Name of Person Responsible for my Dental Costs	
Contact Number for Responsible Person	

(Where applicable)- I give my permission for my details of my dental visits and treatment to be disclosed to the above named persons for the purpose of fee payment	
Signed	Date

I understand that a minimum of 24 hours notice must be given to change or cancel an appointment. A cancellation fee will apply if changes are made with less than 24hrs notice.	
Signed	Date

Confidential Medical Health History

GP Name	
GP telephone number	
Address	Post Code

Have you been seen by your GP during the past year?							Y	N
Are you presently under medical care or taking any medication? If yes, please list your medications on the sheet at the back of this form.							Y	N
Are you or have you taken steroids in the past two years?							Y	N
Have you ever had a prolonged illness or been hospitalized?							Y	N
Have you ever had any major/serious operations or radiation therapy?							Y	N
Do you or have you had any of the following?							Y	N
Rheumatic fever	Y	N	High blood pressure	Y	N	Low blood sugar	Y	N
Congenital heart problem/ cardiac pacemaker	Y	N	Low blood pressure	Y	N	Hiatus hernia/stomach trouble	Y	N
Heart attack/angina	Y	N	Jaundice, hepatitis, liver disease	Y	N	Asthma /chest problems/hay fever	Y	N
Heart murmur	Y	N	HIV/AIDS	Y	N	Epilepsy	Y	N
Have you diabetes?							Y	N
Has any member of your close family had diabetes? (mother / father / brother or sister, child)							Y	N
Have you ever had a stroke, mini stroke, TIA, blackout or faint?							Y	N

Do you have, or have you had, any contact with Hepatitis or HIV/AIDS carriers which is likely to put you at risk from either of these viruses?	Y	N
Did you, as a child or since, have brain surgery, growth hormone treatment prior to the mid 1980's or have a close relative with CJD?	Y	N
Do you bleed or bruise easily? Have you or any relative had any severe bleeding problems?	Y	N
Have you ever had any ill effects following dental treatment?	Y	N
Have you ever had any ill effects following local anaesthetic?	Y	N
Have you ever had any problems following tooth extraction?	Y	N
Are you allergic to, or made ill by, any medications?	Y	N
Have you had any ill effects from penicillin?	Y	N
Have you had any ill effects from any other antibiotic?	Y	N
Have you ever had any ill effects from aspirin?	Y	N
Are you allergic to any food or drink, cleaning, hair or beauty product, metal, material (e.g. latex) bee /wasp sting etc.?	Y	N

Do you or have you ever smoked?		How many units of alcohol do you drink / week	/week
☐ Yes, I currently smoke	per day	Cigarettes ☐ Roll my own ☐ E cigarettes ☐ Pipe ☐ Cigars ☐	I am trying to give up ☐ I have tried before to give up ☐ I am a contented smoker ☐
☐ I gave up smoking	I used to smoke per day	I gave up Month(s) ago Year(s) ago	*(Delete as appropriate)*
☐ I have never smoked			

Do you have any problems with remembering things?	Y	N
Is there someone close to you who helps you with remembering things such as appointments? Would you like us to inform them of appointment dates or details of treatments or information that would help you better access dental care?	Y	N

Please contact-		Relationship to me	

Applicable to women only		
Are you pregnant, or is it possible that you might be pregnant?	Y	N
Are you taking the contraceptive pill? *Certain medications might compromise its effectiveness.*	Y	N

Is there any other information about your medical history that might be important? If so, please list below.

Please list all of your medications below (pills, puffers, injections, creams, ointments, sprays) Don't forget to include any vitamins, supplements herbal medications or self prescribed medication. Continuation Sheets for medications are available if you need them			
Name of Medication	Dose	Frequency	This medication is for

Completed by	Self □	Guardian □
Signed by Patient	Signed by Dentist	
Date	Date	

Subsequent Visits	
List changes since last visit	
Signed By Patient	Signed by Dentist
Date	Date

List changes since last visit	
Signed by Patient	Signed by Dentist
Date	Date

List changes since last visit	
Signed by Patient	Signed by Dentist
Date	Date

List changes since last visit	
Signed by Patient	Signed by Dentist
Date	Date