



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	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Address	
	Postcode
Daytime number	Evening number
Mobile number	Twitter account
Email address	
Where possible, please contact me by:	
<input type="checkbox"/> E mail	<input type="checkbox"/> Post
<input type="checkbox"/> Text message	
Occupation	Company name
How did you hear about us? Please tick all appropriate boxes	
<input type="checkbox"/> Recommendation	<input type="checkbox"/> Referral by dentist/doctor
<input type="checkbox"/> Online Search	<input type="checkbox"/> Website
<input type="checkbox"/> Yell	<input type="checkbox"/> Facebook
<input type="checkbox"/> Phone Book	<input type="checkbox"/> 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?	<input type="text" value="Y"/> <input type="text" value="N"/> <input type="text" value="?"/>

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
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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
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Confidential Medical Health History

GP Name	
GP telephone number	
Address	Post Code

Have you been seen by your GP during the past year?	<input type="checkbox"/> Y	<input type="checkbox"/> 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.	<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you or have you taken steroids in the past two years?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had a prolonged illness or been hospitalized?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had any major/serious operations or radiation therapy?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you or have you had any of the following?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Rheumatic fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
High blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N
Low blood sugar	<input type="checkbox"/> Y	<input type="checkbox"/> N
Congenital heart problem/ cardiac pacemaker	<input type="checkbox"/> Y	<input type="checkbox"/> N
Low blood pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hiatus hernia/stomach trouble	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart attack/angina	<input type="checkbox"/> Y	<input type="checkbox"/> N
Jaundice, hepatitis, liver disease	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma /chest problems/hay fever	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart murmur	<input type="checkbox"/> Y	<input type="checkbox"/> N
HIV/AIDS	<input type="checkbox"/> Y	<input type="checkbox"/> N
Epilepsy	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you diabetes?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Has any member of your close family had diabetes? (mother / father / brother or sister, child)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had a stroke, mini stroke, TIA, blackout or faint?	<input type="checkbox"/> Y	<input type="checkbox"/> 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?		<input type="checkbox"/> Y	<input type="checkbox"/> 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?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you bleed or bruise easily? Have you or any relative had any severe bleeding problems?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had any ill effects following dental treatment?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had any ill effects following local anaesthetic?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had any problems following tooth extraction?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you allergic to, or made ill by, any medications?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you had any ill effects from penicillin?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you had any ill effects from any other antibiotic?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever had any ill effects from aspirin?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you allergic to any food or drink, cleaning, hair or beauty product, metal, material (e.g. latex) bee /wasp sting etc.?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you or have you ever smoked?		How many units of alcohol do you drink / week <input type="text"/> /week	
<input type="checkbox"/> Yes, I currently smoke <input type="text"/> per day		Cigarettes <input type="checkbox"/> Roll my own <input type="checkbox"/> E cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/>	<input type="checkbox"/> I am trying to give up <input type="checkbox"/> I have tried before to give up <input type="checkbox"/> I am a contented smoker
<input type="checkbox"/> I gave up smoking <input type="text"/> I used to smoke <input type="text"/> per day		<input type="text"/> I gave up <input type="text"/> Month(s) ago <input type="text"/> Year(s) ago (Delete as appropriate)	
<input type="checkbox"/> I have never smoked			
Do you have any problems with remembering things?		<input type="checkbox"/> Y	<input type="checkbox"/> 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?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Please contact-	<input type="text"/>	Relationship to me	<input type="text"/>
Applicable to women only			
Are you pregnant, or is it possible that you might be pregnant?		<input type="checkbox"/> Y	<input type="checkbox"/> N
Are you taking the contraceptive pill? <i>Certain medications might compromise its effectiveness.</i>		<input type="checkbox"/> Y	<input type="checkbox"/> N

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

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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 <input type="checkbox"/>	Guardian <input type="checkbox"/>
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	