Brunswick Dental Confidential Medical History

Your dentist needs to know of any problems which may affect your treatment.
Please answer all questions as accurately as possible.

Title (Mr, Mrs, Ms etc.)	
Surname	
First name	
Date of birth	
Gender	
Address	

Occupation	
Telephone home	
Telephone mobile	
Telephone work	
E-mail address	
Doctors name and Address	

	Please tick		
ARE YOU	**YES**	**NO**	**DETAILS**
1. Attending or receiving treatment from a doctor, hospital, clinic or specialist?			
2. Taking any medicines, including creams, ointments or herbal remedies?			
3. Being treated, or have you been treated with steroids in the past 2 years?			
4. Allergic to any medicines or tablets?			
5. Allergic to anything else?			
6. Pregnant?			
HAVE YOU			
1. Had rheumatic fever?			
2. Ever suffered jaundice or hepatitis?			
3. Been told you have a heart complaint?			
4. Ever had your blood refused by the Blood Transfusion Service?			
5. Ever had a bad reaction to a general or local anaesthetic?			
6. Ever had an orthopoeadic joint replacement?			
DO YOU			
1. Bleed excessively from cuts or if you have a tooth extracted?			
2. Suffer bronchitis, asthma or any other chest condition?			
3. Suffer from diabetes?			
4. Have any blood pressure problems?			
5. Suffer from epilepsy?			
6. Units of alcohol consumed per week?			
7. What is your current weight?			
8. Do you smoke? If yes, how many per day?			
If there is any other aspect of your medical history not mentioned please indicate in the box provided			

Completed by Self/ Parent/ Guardian **SIGNATURE**_____**DATE**_____