Tooth Brushing Habits

How many times a day do you clean your teeth?			
Twice daily	Once daily	Less than once a day	Brushing by parent/carer
Do you use a fluoride toothpaste?			
Yes		No	

Medical History Update

Completed by (please tick)	Self		Parent		Other	
Patient signature			Date			
Dentist signature			Date			

Please check that the health information on this form is still correct (including information on smoking and drinking). If not, amend as necessary or note any changes below.

Date	Any changes?	List changes below	Initials

Confidential Medical History Form

Bromley Healthcare community first

Title:		Last name:			
		First name:			
Date of Birth:			Sex:		
NHS number:					
Address:					
				Postcode:	
Telephone:			Mobile:		
Email:					
School/Occupation:					
Language:			Interpreter?		

Next of Kin Name:			
Telephone:		Relationship:	

Doctors/GP Details

Name:			
Address:			
Telephone:		Postcode:	

Social Worker Details Not applicable ☐

Name:		Telephone:	

Vaccination status: Up-to-date ☐ Unknown ☐

Please tick all that apply:

Learning Disability		Communication difficulties:	
Autism		Please write here	
ADHD		Mobility Issues	
Developmental Delay		Wheelchair User	
Syndrome: Please write here		Housebound	
Weight over 20 stone		Dementia	

Are you currently	Yes	No	Details
Receiving treatment from a doctor/hospital/clinic?			
Carrying a medical warning card			
Wearing a Pacemaker?			
Pregnant or possibly pregnant?			

Have you ever suffered from	Yes	No	Details
Allergies to medicine, substances or food?			
Hayfever, Eczema			
Fainting Attacks, Giddiness, Blackouts, Epilepsy Brain Injury/Stroke Mental Health Issues			
Heart Problems (Angina or MI) Blood Pressure Problems			
Chest/Breathing Problems Asthma COPD			
Diabetes, Thyroid, Adrenal			
Liver Disease (Jaundice/Hepatitis)			
Kidney Disease			
Acid Reflux, Hiatus Hernia, Ulcerative Colitis, Crohns			
Bone or Joint Disease Arthritis Osteoporosis			
Bleeding Disorders			
History of cancer			
Infectious Diseases, including HIV?			
DNAR signed?			

Medication

Are you currently	Yes	No	Details
Taking or have taken steroids in the past 2 years			
Taking any blood-thinning medication such as Warfarin, Aspirin or Clopidogrel, Dabigratran? Please specify and give your most recent INR if applicable.			
Taking Bisphosphonates or have you in the past 10 years (e.g. Alendronic Acid/ Risedronate/Etidronate)			

Please list any prescribed or non-prescribed medicines below

Is there anything else that you would like us to know?

Alcohol and Smoking

How many units of alcohol do you drink per week?	_____ units per week

	Yes	No	In the Past	Times per day
Do you smoke any tobacco products?				
Do you chew tobacco, pan, use gutkha or supari now?				