Central Orthodontics

MEDICAL QUESTIONNAIRE

Last Name ______________________________________ First Name ____

Date of Birth ____/_____/______ Sex: Male ☐ Female ☐

Address ____ Post Code _________________

Mobile Tel No ______________________________________ Home Tel No ___________________________________

E-mail Address _____________________________________ Occupation/School _______________________________

Dentist Name & Address ____

Doctors Name & Address ____

Do you have or have you suffered from: (please tick as appropriate)

Any Heart Complaint	Yes ☐ No ☐	Blood Pressure	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Asthma/Chest Problems	Yes ☐ No ☐	Allergies	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
Kidney Disorder	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐	Liver Problems	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Medication	Yes ☐ No ☐	Thumb/finger sucking	Yes ☐ No ☐

Do you carry a medical warning card Yes ☐ No ☐ Have you had any operations Yes ☐ No ☐

Do you smoke Yes ☐ No ☐ How many units of alcohol do you drink per week ____________

Please provide further details including any allergies, pills, tablets or other medication that you take:

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Additional Requirements or Special Needs: (please tick as appropriate)

☐ Visual impairment ☐ Communication difficulties ☐ Wheelchair user

☐ Hearing difficulties ☐ Mental health difficulties ☐ Learning difficulties

☐ Physical disability ☐ Other ☐ None

Questionnaire completed by:

Print name ____

Relationship to patient ____

Signature ____________________________________ Date____/____/_____

For official use

Patient No ______________ Orthodontist/Therapist ____________________________

Date ____/______/______