Complete Orthodontics and Dental Care

Confidential Patient Questionnaire and Medical History

Patient Details	
Surname:	Mr / Master / Mrs / Miss / Ms
First Name:	Male/Female:
Home Address:	Date of Birth:
Suburb:	Post Code:
Occupation:	Work Phone:
Home Phone:	Mobile Phone:
Email:	

Emergency Contact Details		
Name:	Contact no:	Relationship:

Emergency Contact Details	
Doctor:	Contact no:

Medical History	Yes	No
Are you currently receving any medical tretment?		
Details:		
Have you been a patient in hospital in the last two years?		
Details:		
Are you currently taking any medication?		
Details:		
Have you experienced any side effects from anaesthetics, pain killers or any drugs?		
Details:		
Have you had a general health check up in the last two years?		
Have you had any prosthetic surgery?(ie. Hip replacement, heart valve)		
Details:		
Are you pregnant? If so how many Months		
Are you allergic to rubber?		

Medical History	Yes	No
Do you have a blood clotting or bruising disorder?		

Have you ever had any of the following? Please tick where applicable

☐ Rheumatic Fever	☐ Heart Trouble	☐ High Blood Pressure
☐ Asthma	☐ Arthritis	☐ Hepatities A, B or C
☐ Bronchitis or Chest problem	☐ Severe headaches/migraines	☐ Epilepsy
☐ Gastric Problem	☐ Diabetes	☐ Kidney Trouble
☐ Drug Dependence	☐ Cold Sores	☐ Depressive illness
☐ Anaemia	☐ Learning Disability	☐ Other(please Specify)

Dental History		Yes	No
Name of current / last Dentist:			
Approximate date of last Dental check up:	☐ 6 Months	☐ 1 Year	☐ Longer
Do you have any dental problem at present?			
Do you become anxious or uncomfortable when receiving dental treatment?			
How do you think you/the patient will react to treatment?	☐ Well	☐ Poor	☐ Average
Where did you hear about us?			

All staff recognize and support the patient's right to confidentially of all treatment, personal history and records.

SUBMIT