PATIENT DETAILS				
Name			MALE	FEMALE
Date of Birth				
Address				
Post Code				
Contact Details	Home		Mobile	
☐ Please tick to confirm that Suffolk Orthodontics can use your email address and mobile telephone number provided for correspondence and communication.				
E-Mail				
Occupation/ Student				
Next of Kin				
Dentist Name				
Doctor's Name				
Where did you hear about us?				
GDP	Website	Internet	recommendation	Other

MEDICAL HISTORY QUESTIONNAIRE SUFFOLK ORTHODONTICS			
Name			
Please answer the following on behalf of the patient.			
	Yes	No	Additional Comments
Do you have or have you had any heart problems or had a murmur?			
Are you aware of any blood pressure problems?			
Do you suffer with epilepsy?			
Have you had rheumatic fever or chorea?			
Are you a smoker?			
Do you drink alcohol? If yes, how many units?			
Have you undergone heart surgery or had a pacemaker fitted?			
Do you suffer from asthma, eczema or hay fever? If yes to asthma, what type of inhaler?			
Do you suffer from chest problems?			
Do you have any allergies?			
Have you ever had jaundice or any liver/kidney disease?			
Have you had a general anaesthetic?			
Are you a diabetic? If yes, what is your usual reading?			
Have you ever experienced prolonged bleeding or do you bruise easily?			
Are you receiving medical treatment at present? If yes, please list medication.			
Are you taking any medication?			
Do you suffer from blackouts?			
Are you pregnant?			
Diagnosed with either Asperger's or autism?			
Is there anything else you would like to discuss confidentially?			

Signature ……………………………………………………… Relationship to Patient ………………………….....

Signature …………………………………………………… Relationship to Patient …………………..………