Dorset County Hospital
NHS Foundation Trust

ORTHODONTIC DEPARTMENT

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Patient Name:	Date:
Patient Address:	Date of Birth:
Name of Parent/Guardian/Next of Kin:	Address of Parent/Guardian/Next of Kin:
Email Address: Home Telephone Number: Parent/Guardian/Next of Kin Mobile Number: Work Number (If Applicable):	Doctor's Name: Surgery Address:
Dentist's Name +/or Practice Details:	Name of School/College/Place of Employment:

I **DO / DO NOT** wish to receive a copy of any letters relating to **MY / MY CHILD'S** care within the Orthodontic Department

Signature: …… Date: ……..

Date: ……..

Date: ……..

PLEASE TURN OVER

	YES	NO	DETAILS
ARE YOU:			
1. Attending or receiving treatment from a Doctor, Hospital, Clinic or Specialist (other than us)?			
2. Taking any medicines from your Doctor? (tablets, creams, ointments, injections, other)			
3. Taking or have you taken Steroids in the last two years?			
4. Allergic to any medicines (such as Penicillin)?			
HAVE YOU:			
1. Had rheumatic fever or ever been told you have a heart murmur/problem?			
2. Had hepatitis or jaundice (liver disease)?			
3. Had kidney disease?			
4. Had a reaction to local or general anaesthetic?			
5. Been in Hospital? If "YES" what for and when?			
DO YOU SUFFER FROM:			
1. Arthritis?			
2. Hayfever, eczema or any other allergy?			
3. Bronchitis, asthma or other chest condition?			
4. Fainting attacks, giddiness, blackouts or epilepsy?			
5. Diabetes?			
6. Bruise easily or tend to bleed for a long time after injury or tooth extraction?			
7. Any infectious diseases (including HIV and hepatitis)?			
8. Heart problems, angina, blood pressure or stroke?			
9. Cold sores?			
10. Does your child have any learning disabilities, special needs, ADHD or Autism?			
11. Are there any other aspects of your health that you think we should know about? e.g. Do you smoke?			
OTHER INFORMATION:			
1. Have you had any Orthodontic treatment outside this Department?			
2. Do you play a brass, reed or woodwind instrument?			
3. Have you suffered any blows/accidents to the front teeth?			
4. Have you sucked your finger/thumb in the past?			
5. Have you ever had clicks or pain from your jaw joints?			
6. Is the family leaving the area in the near future?			

Completed by Self / Parent / Guardian / Next of Kin

Signature: ……

Date: ……

Date: ……

Date: ……