

**IS THE PATIENT**

Receiving treatment from a doctor, hospital or clinic? **Yes No**

Taking steroids (now or in the last 2 years)? **Yes No**

Taking any other medicines or drugs e.g. tablets, creams, injections or inhalers? **Yes No**

Allergic to any medicines, foods or materials e.g. latex? **Yes No**

**DOES THE PATIENT**

Have any heart problems? **Yes No**

Have any chest problems e.g. asthma or bronchitis? **Yes No**

Have fits, fainting attacks or blackouts? **Yes No**

Have diabetes? **Yes No**

Have a bleeding disorder? **Yes No**

Have kidney disease? **Yes No**

Have liver disease? **Yes No**

Carry a medical warning card, bracelet or warning token? **Yes No**

Please give details below

**HAS THE PATIENT EVER**

Had rheumatic fever? **Yes No**

Had jaundice e.g. hepatitis? **Yes No**

Had any other serious illnesses? **Yes No**

Been admitted to hospital for any operations? (if yes, what for and when?) **Yes No**

Had a bad reaction to a local anaesthetic? **Yes No**

Had a bad reaction to a general anaesthetic? **Yes No**

Bled excessively following an injury, surgery or a tooth extraction (or has anyone in the family)? **Yes No**

Please give details below

**Is there anything else about the patient's health or activities that you think the orthodontist should know about?**

**DENTAL QUESTIONS**

Has the patient worn a brace before? **Yes No**

If yes, what kind of brace was this? .....

If yes, who provided the treatment? .....

Has the patient ever injured his/her teeth **Yes No**

If yes, please describe the injury .....

**WHO COMPLETED THIS QUESTIONNAIRE?**

Print name .....

Relationship to the patient .....

Signature ..... Date .....

**Please make sure that any changes to the patient's medical history are reported to the orthodontist straightaway.**

**BOS Confidential Medical History Form**

**We need to ask patients about their general health so that we can treat them safely. Please write the PATIENT'S details below and then answer the health questions about the PATIENT. All information will be kept confidential.**

Surname ..... Mr. Mrs. Ms. Miss. Other.....

First Names .....

Male / Female ..... Date of Birth .....

Address .....

.....Postcode.....

Tel. home ..... Tel. work .....

Tel. mobile .....e-mail address .....

School/Occupation .....

Doctor's Name & Address .....

Dentist's Name & Address .....