NHS MEDICAL QUESTIONNAIRE

PRIVATE AND CONFIDENTIAL

Please complete the following to enable us to treat you in the best and safest way

DETAILS

Surname: _____ First Name:_____

Address: _____ Male/Female_____

_____ Preferred contact No._____H/W/M

Post Code:_____ Other:_____H/W/M

Date of Birth:_____ Email:_____

Name Of School /College_____

Name of Parent/Guardian:_____

Name of your Medical Practitioner:_____

Name and address of your dentist:_____

Have you ever been to another orthodontic practice YES/NO

Name of Practice_____

Has a family member attended this practice for treatment YES/NO

Name(s)_____

Please tick if the answer is yes & give details where necessary.

Are you:

1) Attending or receiving treatment from a doctor?_____ ☐

2) Taking or using any medicine, pills, tablets, inhalers, ointments, injection or another drug._____ ☐

3) Allergic to or ever had any bad reaction to any medicines , substance or food_____ ☐

Have you:

1) Had rheumatic fever?_____ ☐

2) Ever been told you have a heart murmur or heart problem? _____ ☐

3) Had hepatitis or jaundice? _____ ☐

Do You:

1) Suffer from hay fever, eczema, asthma or any other allergy?_____ ☐

2) Have fainting attacks, giddiness, blackouts or epilepsy?_____ ☐

3) Have diabetes or does anyone in your family? _____ ☐

4) Consume Alcohol beyond recommended levels or smoke? _____ ☐

5) Bruise easily or bleed so as to cause you to be worried?_____ ☐

6) Suffer from cold sores? _____ ☐

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Ethnic Origin

The following is an NHS requirement and follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act. This is not compulsory and please tick "Declined" if you wish. Otherwise, please tick appropriate box

White British		Asian or Asian British Indian		Black or Black British Caribbean	
White Irish		Asian or Asian Pakistani		Black or Black British African	
White Other		Asian or Asian Bangladeshi		Other Black Background	
White and Black Caribbean		Other Asian Background		Any other Ethnic Group	
White and Black African		Chinese		Patient Declined	
White and Asian					

Any other information you feel we should be aware of:

_____

_____

Electronic privacy and using your information

Notice to patients/parents – please indicate Yes or No

Our patient privacy policy is available on request or can be accessed on our website

www.meltonorthodontics.co.uk

Are you happy :

to receive text and email messages from us about your treatment	Yes	No
to receive information e.g appointments, treatment plans,photos by text or email	Yes	No
for us to use your anonymised info, photos or models for research or on the website	Yes	No
to receive info relating to the products and services of the practice by text or email	Yes	No

If you wish to unsubscribe to this service at any time please just let us know

Signature (Parent/Guardian) Date

NB Should you change your address, telephone number or dentist, please advise Reception immediately.

UPDATED: DATE_____BY_____

I confirm I have checked this questionnaire and that there are no changes:

Update by :

Signed	Date	Signed	Date
Signed	Date	Signed	Date