Watford Orthodontics Medical History and Contact Details Update

Personal Details

Name: ..... Title: ..... NHS no: .....

DOB: ..... Occupation/School: .....

Address: .....

.....

..... Postcode: .....

☏ daytime: ..... ☏ evening: .....

☏ mobile: ..... Email: .....

Health Questionnaire

Are you taking any medications?	□ Yes	□ No
Are you allergic to anything?	□ Yes	□ No
Do you have any heart (inc murmurs) or chest problems?	□ Yes	□ No
Have you ever had Rheumatic fever?	□ Yes	□ No
Have you ever had any operations?	□ Yes	□ No
Do you bleed or bruise abnormally?	□ Yes	□ No
Do you suffer from diabetes, liver or kidney disease?	□ Yes	□ No
Could you be pregnant?	□ Yes	□ No
Do you have any disability?	□ Yes	□ No

Please give further details below (including medications and doses): .....

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Social History

Do you smoke?	□ Yes	□ No
How many per day:		
Would you like help to stop smoking?	□ Yes	□ No
Do you consume alcohol?	□ Yes	□ No
Units per week:		

Details of Person Completing this Form

Name: ..... Signature: .....

Relationship to Patient: ..... Date: .....