Susan Carpenter
ORTHODONTIST
BDS (Otago), FDSRCS (Eng), MOrth (Eng), MSc (London)

Registered Specialist Orthodontist

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Patient Confidential Medical History

Patient Details

First Name: _____ Surname: _____

Preferred Name: _____ Mr / Mrs / Ms / Master / Miss

Phone: Hm: _____Wk:_____ Mob_____

Postal Address: _____

_____ Post Code _____

Email:_____ Date of Birth: ____ /____/_____

Name of Dentist: _____ Date of last dental check:_____

Occupation/Name of School: _____

Mother/Guardian Details (If patient under 18 years)

Name: _____ Mr / Mrs / Miss / Ms

Address (if different from above): _____

Phone (if different from above): Hm: _____ Wk:_____ Mob_____

Email: _____

Father/Guardian Details (If patient under 18 years)

Name: _____ Mr / Mrs / Miss / Ms

Address (if different from above): _____

Phone (if different from above): Hm: _____ Wk:_____ Mob_____

Email: _____

Other family members who have seen Dr Susan Carpenter: _____

How did you hear about us: Friend/Relative ☐ Dental Nurse/Dentist ☐ Internet ☐ Other ☐

Have you visited our website: Yes ☐ No ☐

PTO

1. Are you at present taking any medicine, drugs, tablets prescribed by a doctor or dentist? YES / NO

   Name of medication _____

   _____

2. Have you been prescribed any medicine, drugs or tablets in the last three months? YES / NO

   Name of medication _____

3. Have you ever had any allergies to medicines, or other substances (eg Latex)? YES / NO

   Name of medication/substance _____

4. Have you recently been under the care of your Medical Practitioner? YES/ NO

   Reason _____

5. Have you been a patient in hospital over the last two years? YES / NO

   Reason _____

6. Have you ever had any of the following:

☐ Heart Trouble	☐ Heart Murmur	☐ Rheumatic Fever
☐ Stroke	☐ Allergies	☐ High Blood Pressure
☐ Asthma	☐ Bronchitis	☐ Diabetes
☐ Epilepsy	☐ Anaemia	☐ Jaundice
☐ Hepatitis	☐ Excessive Bleeding	

   Give brief details _____

7. Have you ever had contact with:
   HIV virus YES / NO
   Hepatitis B virus YES / NO
   Hepatitis C virus YES / NO

8. Have you had any other serious illness?

   Please give details _____

9. Do you smoke? YES / NO

10. Women – are you pregnant now? If so, how many weeks? _____

11. Is there any other information that we may find helpful (e.g. behavioural disorders, learning difficulties, dental anxieties, etc)? YES / NO

    _____

12. Do you have dental / medical insurance cover? YES / NO

    If so, please specify _____

Patient/Parent/Guardian Signature _____ Date _____
(Parent/Guardian to sign if patient under 18 years)