ORTHO:DONTIST
Donna Batchelor

PATIENT HEALTH QUESTIONAIRE

Please answer all of the following questions and bring this form with you when you attend your consultation. Thank you

Patients Name: _____ _____
(First name) (Surname)

Names of Parents or Guardian: Mother:_____ Father: _____
Address(es): _____ _____
_____ _____
_____ _____
Postal Code: _____ _____

Telephone: Home:_____ _____
Mobile:_____ _____

Email address: _____

Patients Date of Birth: _____/_____/_____

Who were you referred by (Dentist/Dental Nurse/Friend):_____
Name of your Family Dentist: _____

Name of School currently attending:_____
Person/s Responsible for all Accounts:_____
Billing address (if different from above):_____
Name of General Doctor:_____ Specialist:_____ illness being treated:_____
What (if any) serious illnesses have you had in the past: _____
List any medications being taken at present: _____
Have you had any allergies or sensitivities to: Penicillin: Yes/No
Other medications:(List)_____
Latex: Yes/No Nickel: Yes/No
Have you ever had Heart Valve Disease/ Rheumatic Fever/ Heart Murmur:Yes/No:_____
Have you ever had chest trouble,asthma or TB: Yes/No:_____
Do you get short of breath, have high blood pressure or heart trouble: Yes/No: _____
Have you ever had abnormal bleeding or bruising: Yes/No:_____
Have you ever had jaundice or hepatitis:Yes/No:_____
Have there ever been any significant illnesses within your immediate family:Yes/No:____

Signed:_____ (Parent/Guardian) Date:_____/_____/_____