PARK LANE ORTHODONTICS

EMBRACING YOUR FUTURE SMILE

PATIENT QUESTIONNAIRE

Name: Date of Birth:

Address:

Postcode:

Tel: Occupation:

Mobile: Email:

How did you hear about Park Lane Orthodontics?

Please answer the following questions to help us understand your treatment needs.

What are your main concerns about the appearance of your teeth?

If you had a magic wand, what would you like to happen to your teeth?

If we could grant this wish, what would it mean to you?

Is there an important event happening in your life that has prompted you to seek treatment, and when is this event happening?

What would prevent you from going ahead with treatment?

PTO

MEDICAL QUESTIONNAIRE

Medical GP's Name:

Address:

If you answer yes to any of the following questions, please give brief details in the space provided, including the name and dose of any medication taken.

	YES	NO
Do you have a heart murmur or heart defect?	☐	☐
Have you ever had heart surgery?	☐	☐
Have you ever had Rheumatic Fever?	☐	☐
Asthma, Bronchitis or any other lung disorder?	☐	☐
Have you any allergies to everyday objects, drugs or latex?	☐	☐
Have you ever had jaundice or Hepatitis?	☐	☐
Do you suffer from epilepsy or a related disorder?	☐	☐
Have you or your immediate family any history of Diabetes?	☐	☐
Do you suffer frequent mouth ulcers?	☐	☐
Have you ever had chemotherapy or radiotherapy?	☐	☐
Have you taking any medication at present?	☐	☐
Have you any blood disorders, including anaemia?	☐	☐
Have you ever had a serious illness or operation?	☐	☐
Do you smoke? If so, how many per day?	☐	☐
If you drink alcohol, how many units per week?	☐	☐
Is there anything else that you feel may be relevant?	☐	☐
Ladies: If you think you may be pregnant please tell us.	☐	☐

I confirm that I have answered the above questions to best of my knowledge.

Signed: Date:

Relationship to patient:

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