**PRIVATE PATIENT**

**HINCHLEY WOOD PRACTICE MEDICAL HISTORY FORM**

**Thank you for choosing Hinchley Wood Orthodontic Practice. Could you please fill out this form completely in order to help us understand and care for you/your child better. If you have any questions or concerns please do not hesitate to ask for assistance.**

Patient Name ........................................................................................................Date of Birth ........................................

Address .............................................................................................................................................................................

.............................................................................................................................. Postcode .............................................

Tel. No: ................................................................................. Mobile: ...............................................................................

Email (please write carefully): ......................................................................................... Male: ........... Female: ............

Name/address of General Dentist: ....................................................................................................................................

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**DENTAL HISTORY:**

Have you/your child had any previous orthodontic treatment?

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Have you/your child ever had any injuries to the mouth, head or teeth?

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Have you/your child sucked his/her thumb, fingers or pacifier in the past?

Yes: ...................................................................................... No: ......................................................................................

Does the habit still exist: Yes ..................................................... No: ..................................................................

**MEDICAL HISTORY:**

Are you/your child taking any prescription and/or any over the counter medication?

If yes please list: .................................................................................................................................................................

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Are you/your child allergic to any medication?

If yes please list: .................................................................................................................................................................

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Are you/your child allergic to any food or materials?

If yes please list: .................................................................................................................................................................

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Have you/your child had any history or ever been diagnosed with any of the following:

Anaemia Diabetes

Allergy/Hay fever Growth problem Malignant hyperthermia

Arthritis/Rheumatism Hearing loss/aids/implants Pneumonia

Heart murmur Polio Liver problems

Asthma Heart problem/surgery Rheumatic fever

Attention Deficit Disorder Haemophilia Tuberculosis

Autism Hepatitis Bleeding Disorder

Behaviour/Learning Disabilities HIV/AIDS/blood borne viruses Cerebral Palsy

Epilepsy/seizure Hormonal disturbances Fainting

Other: ................................................................................................................................................................................

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**Patient/Parent/Guardian Signature:** ................................................................................................................................

**Date:** .................................................................................................................................................................................