Accessible Orthodontics
MAKING SMILES STRAIGHT FOR ADULTS & CHILDREN

PATIENT MEDICAL HISTORY FORM

Welcome to Accessible Orthodontics. Please take a moment to complete this **Patient Medical History Form**. If you have any questions or wish to provide us with additional information, please speak with our staff. Thank you for your time and attention with this important document.

First Name/s	
Last Name	
Date of Birth	(Day Month Year) **Age** NEXT b'day …..… yrs
Address	
Phone	

Do you have or have you ever suffered from (**Answer** "Yes" **OR** "No" **in EVERY case**)

	Yes / No		Yes / No
Rheumatic Fever		**Any** heart complaints	
Diabetes		Epilepsy	
Chronic Bronchitis or asthma		Excessive Bleeding	
Hepatitis		HIV (AIDS)	
CJD (Creutzfeldt-Jakob Disease)		Any other serious illness (if **YES** more info needed	

Further information:

Are you currently taking any medication? (*circle*) **Yes / No** **If Yes then please list them**
Do you have any allergies? (*circle*) **Yes / No** **If Yes then please list them**
Are you pregnant? *(circle)* **Yes / No** **Do you smoke?** *(circle)* **Yes / No**
Is there anything else you wish to discuss with the orthodontist? (*circle*) **Yes / No** **If YES, what ?**

If you are unsure about any questions OR if your medical circumstances change, please inform the Orthodontist

Patients/Parents Signature: _____ **Date:** ____ / ____ / _____

Review of Medical Information

[**Est.d Review Dates** (ea. 6 Months – MMM/YY) _____ / ___; _____ / ___; ___ / ___; ___ / ___]

NB: IF 'CHANGES' below **= "Y": NEW MED Hx FORM MUST** be completed & signed (same day)

DATE OF REV	CHANGES	CLINICIAN SIGNATURE	PATIENT/PARENT SIGNATURE
___ / ___ / ___	**Y / N**		
___ / ___ / ___	**Y / N**		
___ / ___ / ___	**Y / N**		
___ / ___ / ___	**Y / N**		

Accessible Orthodontics - # & Repair Tracker

NAME _____

DOB _____ / _____ / 20_____

USE OF THE BREAKAGE SS

1/ each Appointment ensure date entered and **record at least one entry**.
2/ **IF** a Repair (any type) is carried out **THEN** C/N has '# stamp' applied.
3/ Recording of # on this Form will be entered onto # SS. **ENSURE** your entry is clear and accurate
4/ Appropriate clinical note is always entered onto C/N

VG – Very Good G – Good P - Poor VP – Very Poor D – Decalcification

Date	ORAL HYGIENE					WIRES			BRACKETS						ACTION TAKEN			NO #	FTA
	VG	G	P	VP	D	Trimm	#	Lost	1	2	3	4	5	6	Rep	Verb	Writ	Enter X if no #	Enter X if FTA
	Enter 'X' in appropriate box					Enter 'X' in appropriate box			Use single box to indicate each # e.g LL5, UR1						Enter 'X' in appropriate box				