

Medical History

Patient's Name: _____ Age: _____ Chart #: _____

Is patient in good health? Yes No If NO, explain _____

Physician's Name: _____ Phone Number: (____) _____

Is patient under a physician's care now? Yes No If YES, explain _____

Is the patient taking any prescribed or over the counter medication (including birth control)? Yes No

If YES, list medications: _____

Has the patient taken any weight loss medications? (e.g. PhenFen) Yes No

Is the patient allergic to latex? Yes No

Please list any allergies or drug sensitivity: _____

Is the patient pregnant? Yes No If Yes, how many months? _____

Has the patient ever had a blood transfusion? Yes No

Does the patient smoke? Yes No Use Tobacco? Yes No Use recreational drugs? Yes No

Has the patient ever had prolonged bleeding after an injury or extraction? Yes No

Does the patient have a cardiac pacemaker or artificial heart valve? Yes No

Is there any family history of diabetes, heart murmur/problems, tumors? Yes No

Have tonsils and adenoids been removed? If so, at what age? _____ Yes No

Has the patient reached puberty? (Girls- reached menarchy; Boys- has his voice changed?)..... Yes No

Does the patient have a tendency to: Colds? Sore Throats? Ear Infections? Canker Sores?

Please check each box, yes or no, if the patient has ever had any illness or condition listed below. *Please do not leave blank.*

- | | | | |
|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Immunosuppressed |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Nervous/Mental Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Angina | <input type="checkbox"/> Tuberculosis |

Has the patient had any disease, serious illness/surgery, condition or problem not listed above. Yes No If YES, explain below _____

Dental History

Are you pleased with the appearance of your smile? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Does the patient's jaw pop or click when chewing? (TMJ) Yes No

Has the patient had any injuries to the face, mouth or teeth?..... Yes No

Has the patient ever sucked a thumb or fingers? If so, until what age _____ Yes No

Is the patient a mouth breather when sleeping? While awake? Yes No

Has an orthodontist been consulted previously? Yes No

Have siblings or either parent had orthodontic treatment? Yes No

Please list any musical instruments played: _____

What is the reason for orthodontic consultation/ Primary concerns: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays, an oral examination and/or treatment, and employment and credit verification if needed.

Patient/Responsible party signature Date

Office Use Only

Health History Reviewed By: _____ Date: _____	Any Changes in Health History: <input type="checkbox"/> No <input type="checkbox"/> Yes, please list changes _____
Comments: _____	Doctor Signature: _____ Date: _____
	Patient Signature: _____ Date: _____
Any Changes in Health History: <input type="checkbox"/> No <input type="checkbox"/> Yes, please list changes _____	Any Changes in Health History: <input type="checkbox"/> No <input type="checkbox"/> Yes, please list changes _____
Doctor Signature: _____ Date: _____	Doctor Signature: _____ Date: _____
Patient Signature: _____ Date: _____	Patient Signature: _____ Date: _____