MEDICAL HISTORY FORM

NAME ***DATE***

For the following questions, circle yes or no. Your answers are for our records only and will be considered confidential. Please update this information with our office as soon as there are changes in health or treatment.

Are you in good health?					Yes	No
Has there been any change in your general health within the past year?					Yes	No
Date of last physical exam	Are you now under the care of a physician? For what condition?				Yes	No
Name and address of physician.						
Have you had any serious illness, operation or been hospitalized in the last five years? Yes No If so for what illness or problem?						
Are you taking any medicines, including non-prescription or herbal remedies? If so, which ones?					Yes	No
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?						
Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease					Yes	No
Cardiovascular disease: heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion					Yes	No
High blood pressure	Yes	No	Pneumonia		Yes	No
Arteriosclerosis	Yes	No	Respiratory problems, emphysema, bronchitis		Yes	No
Stroke	Yes	No	Tuberculosis		Yes	No
Chest pain upon exertion	Yes	No	Persistent cough or cough that produces blood		Yes	No
Shortness of breath	Yes	No	Stomach ulcer or hyperacidity		Yes	No
Swollen ankles	Yes	No	Persistent diarrhea or recent weight loss		Yes	No
Inborn heart defects	Yes	No	Kidney trouble		Yes	No
Cardiac pacemaker	Yes	No	AIDS or HIV infection		Yes	No
Mitral Valve Prolapse	Yes	No	Persistent swollen glands in neck		Yes	No
Low blood pressure	Yes	No	Problems of the immune system		Yes	No
Asthma or Hay Fever	Yes	No	Fainting spells, dizziness or seizures		Yes	No
Allergy	Yes	No	Epilepsy or other neurological disease		Yes	No
Sinus trouble	Yes	No	Psychiatric care		Yes	No
Diabetes	Yes	No	Anemia or other blood disorder		Yes	No
Hepatitis, jaundice or liver disease	Yes	No	Blood transfusion		Yes	No
Arthritis or painful swollen joints	Yes	No	Abnormal bleeding		Yes	No
Thyroid problems	Yes	No	Treatment for a tumor or growth		Yes	No
Sexually transmitted disease	Yes	No	Cancer		Yes	No
Herpes	Yes	No	Radiation/Chemotherapy		Yes	No
ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:						
Latex	Yes	No	Sulfa Drugs		Yes	No
Metals	Yes	No	Barbiturates, sedatives, or sleeping pills		Yes	No
Red Dye	Yes	No	Aspirin		Yes	No
Local anesthetics	Yes	No	Iodine		Yes	No
Penicillin or other antibiotics	Yes	No	Codeine or other narcotics		Yes	No
Other						
Have you ever had any serious trouble associated with any dental treatment? Yes No						
Have you ever been told you should be premedicated prior to dental appointments?					Yes	No
Are you pregnant?					Yes	No
Do you have any problems associated with your menstrual period?					Yes	No
(For purposes of assessing remaining growth only) At what age did menstrual periods begin?						
Are you nursing?					Yes	No
Are you taking birth control pills?					Yes	No
Is there any other condition, disease, or problem not listed that you think I should know about? Yes No						

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PARENT OR GUARDIAN	***SIGNATURE OF PATIENT OVER 18***

OFFICE USE ONLY: ALERTS OR PREMEDS