



**MEDICAL HISTORY:**

Do you have a personal physician?  Yes  No Date of Last Visit: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your current physical health is:  Good  Fair  Poor Are you currently under the care of a physician?  Yes  No

Please explain: \_\_\_\_\_

Are you taking any prescription / over-the-counter drug?  Yes  No

Please list each one: \_\_\_\_\_

Have you ever had any of the following diseases or medical problems?

- |                                           |                                    |
|-------------------------------------------|------------------------------------|
| Y N Anemia / Radiation Treatment          | Y N Heart Surgery / Pacemaker      |
| Y N Asthma / Arthritis                    | Y N Hemophilia / Abnormal Bleeding |
| Y N Cancer / Chemotherapy                 | Y N Hepatitis                      |
| Y N Congenital Heart Defect               | Y N High /-Low Blood Pressure      |
| Y N Diabetes / Tuberculosis (TB)          | Y N HIV+ / AIDS                    |
| Y N Difficulty Breathing                  | Y N Kidney Problems                |
| Y N Emphysema / Glaucoma                  | Y N Mitral Valve Prolapse          |
| Y N Epilepsy / Seizures / Fainting Spells | Y N Rheumatic / Scarlet Fever      |
| Y N Heart Attack / Stroke                 | Y N Severe / Frequent Headaches    |
| Y N Heart Murmur                          | Y N Sinus Problems                 |

Please list any serious medical condition(s) that you have ever had: \_\_\_\_\_

Are you allergic to any of the following:

- |             |                  |                  |           |
|-------------|------------------|------------------|-----------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin   | Y N Other |
| Y N Codeine | Y N Latex        | Y N Tetracycline |           |

Please list any other drugs that you are allergic to: \_\_\_\_\_

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Have you ever been evaluated for orthodontic treatment?  Yes  No

Have you ever had a serious / difficult problem associated with any previous dental work?  Yes  No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?  Yes  No

Your current dental health is:  Good  Fair  Poor Do you like your smile?  Yes  No

Do your gums ever bleed?  Yes  No Have you ever had an injury occur to your: Mouth Teeth Chin (Please Circle)

Do you have any speech problems? \_\_\_\_\_

Do you generally breathe through your mouth:  Yes  No Awake?  Yes  No Asleep? (Please Circle)

Do you have any missing or extra permanent teeth?  Yes  No

- This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees.
- I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Doctor's comments: \_\_\_\_\_