Medical History

Have you ever had any of the following? Please check those that apply:

___AIDS
___Allergies
___Anemia
___Asthma
___Artificial Joints
___Blood Thinner
___Blood Disease
___Cancer
___Diabetes
___Dizziness

___Epilepsy
___Excessive bleeding
___Glaucoma
___ Hay Fever
___Head Injuries
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Press.
___Jaundice
___Kidney Disease

___Liver Disease
___Mental Disorder
___Nervous Disorder
___Pacemaker
___Pregnancy
___Due Date:
___Radiation TX
___Respiratory TX
___Rheumatism
___Sinus Problems
___Stomach Problems

___Stroke
___Tuberculosis
___Tumors
___Ulcers
___Venereal Disease
___Codeine Allergy
___Penicillin Allergy
___Other

Please answer Yes or No and if Yes, Please Explain

Are you taking any medications?______________________________
Have you ever had any complications following a dental treatment? ______________
____
Have you been admitted to a hospital or needed emergency care in the last two years?
____
Are you currently under the care of a physician?______________________
____
Name of Physician:______________________Phone:____________
Do you have any health problems that need further clarifications?____________
____
What is your main concern regarding you/your child's teeth?______________
Have you ever been treated with orthodontics?____________________
Has anyone in you family been treated with orthodontics?______________
Have you ever been told you grind you teeth?_____________________
Are you aware of any jaw clicking or popping?_____________________
Do your teeth hurt when you wake up in the morning?________________
Are you a mouth breather?_____________________________
When you brush do your gums bleed?_________________________
Do you have a thumb or tongue habit?_________________________
If the patient is under the age of 16, what is the height of the parent?_____Mom____Dad

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at my next appointment.
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______________________________Date:__________Relationship to Patient:__________
Signature of Patient, Parent, or Guardian