

MEDICAL HISTORY FORM

NAME: _____ DATE: _____ AGE: _____

(Check One)
YES NO

1. Are you now under the care of a physician or have you been within the past two years? _____
 If so, for what? _____
 Physician's name _____ Phone No. _____
2. Are you taking any medications? _____
 If so, please list _____
3. Have you been hospitalized in the past two years? _____
 If so, what? _____
4. Have you ever had any allergic reaction (itching, hives, swelling) or any ill effects from medicine (i.e. penicillin, aspirin, codeine, local anesthetic) _____
 If so, from what? _____
5. When you cut yourself, or have tooth extracted, do you have abdominal or excessive bleeding? _____
6. Do you now have a cold, cough, or trouble breathing through your nose? _____
7. Do you Smoke? _____
 If so, how much? _____ For how long? _____
8. Do you get short of breath or limit your physical activity for any reason? _____
9. WOMEN: Are you pregnant? _____
 If so, how many months? _____
10. Have you had or do you have:

	YES	NO		YES	NO
Heart Trouble	_____	_____	Stroke	_____	_____
High Blood Pressure	_____	_____	Heart Valve Replacement	_____	_____
Asthma	_____	_____	Cancer	_____	_____
Bronchitis	_____	_____	Diabetes	_____	_____
Hay Fever	_____	_____	Kidney Disease	_____	_____
Venereal Disease	_____	_____	Liver Disease	_____	_____
Hepatitis (jaundice)	_____	_____	Anemia	_____	_____
Epilepsy	_____	_____	Thyroid Disease	_____	_____
Tuberculosis	_____	_____	Nervous Disorder	_____	_____
Blood Disease	_____	_____	Artificial Prosthesis (Limbs)	_____	_____
Rheumatic Fever	_____	_____	AIDS / HIV Positive	_____	_____
Heart Murmur	_____	_____	Oral Herpes (Cold Sores)	_____	_____
11. Do you have any disease or condition not listed above that you think we should know about?... _____
 If so, what? _____

DENTAL HISTORY

1. Have you had or do you have:

	YES	NO		YES	NO
Gum Disease	_____	_____	Malocclusion (Bad Bite)	_____	_____
TMJ Disease (Jaw Pain)	_____	_____	Impacted Wisdom Teeth.....	_____	_____
Cavities	_____	_____	Tongue or Thumbsucking Habit	_____	_____
Back, Neck or Facial Pain	_____	_____	Discolored Teeth	_____	_____
2. Have you ever had worn braces before? YES NO How many years ago? _____
3. Is this your first orthodontic examination? YES NO
4. When was your last visit to your dentist and what was done? _____
5. What don't you like about your teeth and what specifically do you hope to accomplish with braces? _____

DATE: _____ SIGNED: _____

