Patient Name ____________________

Date of Birth ____________________

MEDICAL HISTORY FORM

Medical doctor's name ____________________

Are you under a doctor's care now? Why? ____________________

Have you been hospitalized during the past two years? Why? ____________________

Please indicate any medications you are taking ____________________

Please list all allergies including any medications or materials ____________________

Do you require medications for dental treatment? ____________________

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- Heart Trouble
- High Blood Pressure
- Heart Murmur
- Rheumatic Fever
- Asthma
- Hepatitis B (serum)
- Excessive Thirst
- Artificial Joints/Hip
- Kidney Trouble
- Yellow Jaundice
- Parathyroid Disease
- Blood Transfusion
- Pain in Jaw Joints
- Psychiatric Care

- Chest Pain
- Shortness of Breath
- Fainting or Dizziness
- Hepatitis A (infec.)
- Lung Disease
- Tuberculosis
- Liver Disease
- Diabetes
- Thyroid Disease
- Allergies
- Hypoglycemia
- Fever Blisters
- Sickle Cell

- Scarlet Fever
- Hay Fever
- Emphysema
- Frequent Cough
- Drug Addiction
- Glaucoma
- Rheumatism
- Arthritis/Gout
- Bruise Easily
- Hemophilia
- Nervousness
- Veneral Diseases
- Contact Lenses
- Chemotherapy

- Cancer
- Herpes
- Ulcers
- Cold Sores
- Congenital Heart Lesion
- Artificial Heart Valve
- Heart Pacemaker
- Heart Surgery
- Blood Disease
- Anemia
- X-ray or Cobalt Tmt.
- Prolonged Bleeding
- Epilepsy Seizures

Have you ever had any other serious illness not circled above? ____________________

Please describe in detail ____________________

DENTAL HISTORY

Family Dentist ____________________

How often do you visit your family dentist for cleanings? ______

Good exp. ____________ Bad exp. ____________

How often do you brush your teeth? ____________________

Do your gums bleed? ____________ ❑ Yes ❑ No

Do you have any discomfort in the teeth, face, jaw-joint? ____________ ❑ Yes ❑ No

Are you aware of your jaws making noises? ______ ❑ Yes ❑ No

Have you had any trauma involving face or teeth? ❑ Yes ❑ No

Do you require premedication prior to dental treatment? ____________ ❑ Yes ❑ No

Other important dental history information? ______ ❑ Yes ❑ No

Previous Ortho Care ____________________

Have parents/siblings had Ortho Care or bite problems? ____________ ❑ Yes ❑ No

ORAL HABITS

Lip biting? ____________ ❑ Yes ❑ No

Difficulty closing lips? ____________ ❑ Yes ❑ No

Mouth breathing? ____________ ❑ Yes ❑ No

Speech problems? ____________ ❑ Yes ❑ No

Swallowing problems? ____________ ❑ Yes ❑ No

Grinding of teeth? ____________ ❑ Yes ❑ No

Thumb/Finger sucking? ____________ ❑ Yes ❑ No

Other ____________ ❑ Yes ❑ No

I have provided this medical history. It is complete and accurate to the best of my knowledge.

X ____________________
Patient/Parent Signature

Reviewed by: ____________________
Doctor

Date: ____________________