Medical History

It is extremely imperative for your benefit, and others that you fill this form out completely. Thank you.

Please Indicate (by checking) if you have had any of the following:

- Heart Disease
- Asthma
- Chronic Cough
- High Blood pressure
- Kidney Trouble
- Stomach Disorder
- Diabetes
- Sickle Cell Disease
- Sinusitis,Hay Fever
- Tuberculosis
- Epilepsy
- Nervous Disorder
- Thyroid disorder
- Hyperactivity
- Bleeding Disorder
- Psychiatric Treatment
- Special Diets
- Rheumatic Fever
- Heart Murmur
- Scarlet Fever
- Frequent Colds
- Immune Deficiency
- Shortness of Breath
- Fever Blisters
- Blood Disease
- Cancer
- Cleft Palate

Who is your Family Physician?
____

Are you allergic to any of the following ?

- Aspirin
- Local Anesthetic
- Penicillin
- Other Antibiotics

Any other allergies to medications or substances?
____

List any current medications you are taking?
____

Do you have any disease, condition, or current problem not listed above?
____

Orthodontic History

Do You like your smile YES NO
Do you like the appearance of your teeth YES NO
Have you consulted another Orthodontist YES NO
Have any other family members had Orthodontic Treatment YES NO
Have you had previous Orthodontic treatment YES NO

What are your concerns/reasons for desiring Orthodontic Treatment?
____
____
____
____

Patient / Guardian Signature________________________________
Doctor Signature___________________________Date__________

Patient Treatment:____
____