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
☐ Tuberculosis
☐ Epilepsy
☐ Nervous Disorder
☐ Thyroid Disorder
☐ Hyperactivity
☐ Bleeding Disorder
☐ Psychiatric Treatment
☐ Special Diets
☐ Rheumatic Fever
☐ Heart Murmur
☐ Scarlet Fever
☐ Immune Deficiency
☐ Shortness of Breath
☐ Fever Blister
☐ Blood Disease
☐ Cancer
☐ Cleft Palate
☐ Liver Disease
☐ Anemia
☐ Bone Density

Whom is your Family Physician?

_____

Women, are you pregnant?

_____

Are you allergic to any of the following?

☐ Aspirin
☐ Local Anesthetic
☐ Penicillin
☐ Other Antibiotics

Any other allergies to medications or substances?

_____

List any current medication you are taking?

_____

List 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_____