Date _____

Your Name _____

Your Dentist _____

MEDICAL DENTAL HISTORY

The following information is essential for this office to provide orthodontic care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your orthodontic needs safely and efficiently. Incorrect information can be dangerous to your health. If you answer yes to any question please give an explanation.

How would you describe your general health? .....Good ____ Fair ____ Poor ____

Have you been in the hospital in the past two years? .....Yes____ No_____

If yes, what for and what date(s) _____

Do you have any medical problems we should know about? .....Yes_____ No_____

If yes, please explain _____

Are you taking any medication and for what purpose(s) _____

_____

Are you allergic to any medications? .....Yes_____ No_____

If yes, please list _____

Have you ever had excessive bleeding requiring special treatment? ....Yes_____ No_____

Have you ever had: (Please circle if yes)

Heart Trouble	Nervous Disorders	Kidney Disease	Psychiatric Treatment
Heart Attack	Tumor or Growth	Glaucoma	Sinus Trouble
Heart Murmur	X-Ray Treatment	Tuberculosis	Thyroid
A Stroke	Arthritis	Ulcers	Diabetes/Hypoglycemia
High Blood Pressure	Asthma	Jaundice	Anemia
Rheumatic Fever	Allergies	Epilepsy	Convulsions/seizures
Endocrine Problems	Fainting or dizziness	Hepatitis A or B	Venereal Disease
Bone disorders	HIV	Liver Disease	(AIDS) Acquired Immune

Do you have any disease, condition or problem not listed? ..... Yes____ No_____

Are you pregnant? .....Yes____ No_____

Have you had any injuries to the face, mouth or teeth?.....Yes____ No_____

If yes, what, and when? _____

Do you have any speech problems? .....Yes____ No_____

Are you a mouth breather? While awake?.....Yes____ No_____

While asleep?.....Yes____ No_____

Have you been informed of any missing or extra permanent teeth? .....Yes____ No_____

Has an orthodontist been consulted previously? .....Yes____ No_____

What is the reason for seeking orthodontic treatment? _____

PLEASE REPORT ANY CHANGE IN HEALTH STATUS IMMEDIATELY.

To the best of my knowledge, the above questions have been answered correctly.

I grant permission to the orthodontist to release information about my health to third party payors, and/or health practitioners.

Print name: _____

Signature: _____