

Medical History

Name: _____ Today's Date _____

Medical Questions:
Does the Patient have a personal Physician? Yes No

Physician's Name: _____
Physician's Phone Number: _____

Patient's current physical health is: Good Fair Poor
Is the Patient currently under the care of a physician? Yes No

Please Explain: _____
Smoke or Use Tobacco in any other form? Yes No
Have metal rods, pins, or implants? Yes No
Taking prescription or over the counter medicines? Yes No
List Medications: _____
Has the Patient ever taken Phen-Fen or Redux? Yes No
If So, When? _____

Has the patient had any of the following conditions?

Abnormal Bleeding	Yes	No	Heart Attack/Surgery	Yes	No
AIDS	Yes	No	Heart Murmur	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No
Artificial Bones/Joints/Valves	Yes	No	Herpes/Fever Blister	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No
Cancer/Chemotherapy	Yes	No	HIV	Yes	No
Congenital Heart Defect	Yes	No	Hospitalized for any reason	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No
Epilepsy	Yes	No	Liver Disease	Yes	No
Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No
Hay Fever	Yes	No	Lupus	Yes	No

Dental Questions:
Has the patient ever been evaluated for orthodontic treatment? Yes No

Has the patient ever had a serious or difficult problem with any previous dental work? Yes No

Patient's current dental health is: Good Fair Poor
Does the patient still have wisdom teeth? Yes No

Speech Problems? Yes No
Have adenoids or tonsils been removed? Yes No
Are you happy with the way your smile looks? Yes No
If not, what would you change? _____
Allergic to Latex or Nickel? Yes No
Heart condition requiring PreMed? Yes No
Pregnant? Yes No

Mitral Valve Prolapse	Yes	No
Pace Maker	Yes	No
Psychiatric Problems	Yes	No
Radiation Treatment	Yes	No
Rheumatic/Scarlet Fever	Yes	No
Seizures	Yes	No
Sickle Cell Disease	Yes	No
Sinus Problems	Yes	No
Stroke	Yes	No
Thyroid Problems	Yes	No
TB	Yes	No
Ulcers	Yes	No

Please List and Explain any other medical conditions:

I have answered the questions on this form to the best of my knowledge as of the date indicated:

Signature of Responsible Party _____ Date _____