MEDICAL HISTORY

Patient Name _____

For the patient named on this form: Place a check in the " yes" (Y) column for each condition that is currently or has ever been applicable. Otherwise place a check in the " no" (N) column.

	Y	N		Y	N
Previous orthodontic treatment	○	○	Frequent shortness of breath	○	○
Dental problems other than routine care	○	○	Sinus trouble	○	○
Tooth extractions (removal)	○	○	Smoker or smokeless tobacco	○	○
Negative reaction to dental care	○	○	Seasonal allergy	○	○
Injury to face or mouth	○	○	Allergy to medication	○	○
Jaw pain	○	○	Hives or rash	○	○
Difficulty moving jaw	○	○	Other allergy	○	○
Difficulty chewing	○	○	Mumps	○	○
Difficulty swallowing	○	○	Chickenpox	○	○
Gag easily	○	○	Venereal disease	○	○
Suck your thumb or fingers	○	○	Fainting or dizziness	○	○
Play a musical instrument	○	○	Thyroid or other endocrine disorder	○	○
Tonsils or adenoids removed	○	○	Frequent headaches	○	○
Speech impairment	○	○	Epilepsy or seizures	○	○
Heart condition	○	○	Emotional or nervous disorder	○	○
Congenital heart defect	○	○	Psychiatric care	○	○
Rheumatic fever	○	○	Severe weight loss or gain	○	○
Chest pains	○	○	Diabetes	○	○
Swollen ankles	○	○	Kidney or liver disease	○	○
Stroke	○	○	Ulcers	○	○
Bleeding problems	○	○	Scarlet fever	○	○
High or low blood pressure	○	○	Ear pain or infection	○	○
Anemia	○	○	Hearing impairment	○	○
Artificial valves or joints	○	○	Glaucoma	○	○
Blood transfusion	○	○	Arthritis	○	○
Compromised immune system	○	○	Cancer or tumor	○	○
HIV or AIDS	○	○	Major surgery	○	○
Lung Disease	○	○	Birth defects	○	○
Asthma	○	○	Other recurrent illness	○	○
Bronchitis	○	○	Taking *any* medications or supplements	○	○
Emphysema	○	○	**FEMALES ONLY:**		
Pneumonia	○	○	Reached menses (first period)	○	○
Tuberculosis	○	○	In menopause	○	○
Frequent colds, sore throat, or cough	○	○	Using birth control medication	○	○
Bisphosphonate medication	○	○	Pregnant	○	○

HISTORY GIVEN BY:_____ DATE:_____

Doctor's Notes:

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Medical alerts to be entered in e-chart? ○ Y ○ N