MEDICAL HISTORY

Patient Name _____

Please check "Y" (yes) for each condition which currently applies or has ever applied to the patient named on this form. Otherwise place a check in the "N" (no) column.

	Y	N		Y	N
Previous orthodontic treatment			Heart condition or heart defect		
Periodontal (gum) disease			Rheumatic heart disease		
Extraction (removal) of permanent tooth			Heart murmur		
Born with extra or missing teeth			Stroke / heart attack / arteriosclerosis		
Severe injury to teeth, mouth or head			High or low blood pressure		
Pain in jaw joint or jaw muscles			Fainting or dizziness		
Difficulty chewing or moving jaw			Bleeding problems		
Difficulty swallowing			Anemia		
Difficulty breathing through nose			Chest pains		
Severe snoring			Swollen ankles		
Removal of tonsils or adenoids			Frequent headaches or migraines		
Severe gag reflex			Vision or hearing impairment		
Oral habit (thumb, finger, pencil etc.)			Epilepsy or seizures		
Impaired speech			Congenital (birth) abnormality		
Brass or woodwind musical instrument			Sensory or developmental issues		
Difficulty tolerating routine dental care			Autism		
Major dental problems not listed here			Mental health treatment or concern		
Smoker / smokeless tobacco / vaping			Eating disorder		
Chronic sore throat			Substance abuse		
Persistent cough			Diabetes		
Frequent shortness of breath			Kidney or liver disease		
Asthma			Thyroid or other endocrine disorder		
Emphysema			Artificial valves or joints		
Sinus problems			Arthritis		
Tuberculosis			Osteoporosis		
Respiratory disease not listed here			Bisphosphonate medication		
Seasonal allergy			Ulcers, gastric reflux or digestive issues		
Allergy to medication			Cancer or tumor		
Allergy to metal or latex			Major surgery		
Other allergy not listed here			Taking *any* medications or supplements		
Recurring hives or rash			Other illness / impairment not listed here		
Skin ailment other than acne			FEMALES: Reached menses (first period)		
Sexually transmitted disease			FEMALES: Menopause		
HIV or AIDS			FEMALES Birth control medication		
Compromised immune system			FEMALES: Currently or possibly pregnant		

HISTORY GIVEN BY: _____ DATE: _____

Doctor's Notes: