

ADULT MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y	N	ABNORMAL BLEEDING	Y	N	HEMOPHILIA
Y	N	ANEMIA	Y	N	HEPATITIS
Y	N	ANY HOSPITAL STAYS	Y	N	HIGH / LOW BLOOD PRESSURE
Y	N	ANY OPERATIONS	Y	N	HIV+ / AIDS
Y	N	ARTIFICIAL BONES / JOINTS / VALVES	Y	N	HOSPITALIZED FOR ANY REASON
Y	N	ASTHMA / ARTHRITIS	Y	N	KIDNEY PROBLEMS
Y	N	BLOOD TRANSFUSION	Y	N	MITRAL VALVE PROLAPSE
Y	N	CANCER/ CHEMOTHERAPY	Y	N	PSYCHIATRIC PROBLEMS
Y	N	CONGENITAL HEART DEFECT	Y	N	SEVERE / FREQUENT HEADACHES
Y	N	CONVULSIONS / EPILEPSY	Y	N	SHINGLES
Y	N	DIFFICULTY BREATHING	Y	N	SICKLE CELL DISEASE/TRAITS
Y	N	DIABETES	Y	N	SINUS PROBLEMS
Y	N	DISABILITIES/HANDICAPS	Y	N	TUBERCULOSIS (TB)
Y	N	DRUG/ALCOHOL ABUSE	Y	N	ULCERS / COLITIS
Y	N	EMPHYSEMA	Y	N	VENEREAL DISEASE
Y	N	FEVER BLISTERS/HERPES	Y	N	ALLERGIES TO LATEX / PLASTIC
Y	N	GLAUCOMA	Y	N	ALLERGIES TO METALS
Y	N	HEART ATTACK / STROKE	Y	N	ALLERGIES TO OTHER MEDICATIONS
Y	N	HEART MURMUR			PLEASE LIST: _____

LIST ANY PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING:

LIST ANY ALLERGIES OR DRUG SENSITIVITY:

FOR WOMEN: ____ Y ____ N ARE YOU PREGNANT?

PHYSICIAN: _____ PHONE # _____ LAST VISIT _____

DENTAL HISTORY

REASON FOR TODAY'S CONSULTATION:

HAVE YOU HAD ANY PREVIOUS ORTHODONTIC TREATMENT	_____	Y	_____	N
HAVE YOU EVER BEEN EVALUATED FOR ORTHODONTIC TREATMENT	_____	Y	_____	N
HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH	_____	Y	_____	N
ARE YOU A MOUTH BREATHER? WHILE AWAKE _____ ASLEEP _____	_____	Y	_____	N
DO YOU NOW / PREVIOUSLY EXPERIENCED DISCOMFORT IN JAW JOINTS	_____	Y	_____	N
PERIODONTAL "GUM" PROBLEMS	_____	Y	_____	N
MISSING PERMANENT TEETH	_____	Y	_____	N
TOOTH GRINDING, JAW CLENCHING, CLICKING OR LOCKING	_____	Y	_____	N
DO YOU NEED TO BE PREMEDICATED BEFORE DENTAL APPOINTMENTS	_____	Y	_____	N

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO CONTACT THIS OFFICE WITH ANY CHANGES IN MY MEDICAL/DENTAL STATUS.

SIGNATURE

TODAY'S DATE

I UNDERSTAND THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS WHERE APPROPRIATE IN DETERMINING A PAYMENT PLAN.

SIGNATURE

TODAY'S DATE