# Confidential Patient Health History

## Medical History

Your current physical health is? ☐ Good ☐ Fair ☐ Poor
Are you under the care of a physician? ☐ Yes ☐ No

_____
Please Explain

Are you taking prescription/over the counter drugs? ☐ Yes ☐ No

_____
Please Explain

Next two questions females only
Has the patient started her monthly periods? ☐ Yes ☐ No
Are you currently pregnant? (Weeks#___) ☐ Yes ☐ No

Are you allergic to the following?

| | Yes | No |
|---|---|---|
| Medication | ☐ | ☐ |
| Any Metals/Plastics | ☐ | ☐ |
| Latex | ☐ | ☐ |

_____
Please list any additional drugs/materials that you are allergic to.

Have you ever had any of the following diseases or medical problems?

| | Yes | No |
|---|---|---|
| AIDS/HIV Positive | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Birth Defects | ☐ | ☐ |
| Bleeding Disorders | ☐ | ☐ |
| Bone Fractures | ☐ | ☐ |
| Cancer/Chemotherapy | ☐ | ☐ |
| Cardiovascular Problems | ☐ | ☐ |
| Chest Pain/Shortness of Breath | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Eating Disorders | ☐ | ☐ |
| Endocrine/Thyroid | ☐ | ☐ |
| Epilepsy/Seizures/Fainting | ☐ | ☐ |
| Frequent Headaches/colds/sore throats | ☐ | ☐ |
| Hay Fever/Asthma/Hives | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| High/Low Blood Pressure | ☐ | ☐ |
| Hospitalized for any Reason | ☐ | ☐ |
| Kidney | ☐ | ☐ |
| Mental Health Problems | ☐ | ☐ |
| Poor Appetite | ☐ | ☐ |
| Skin Disorder | ☐ | ☐ |
| Tonsil/Adenoid Conditions | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Ulcers | ☐ | ☐ |
| Vision/Hearing/Tasting/Speech | ☐ | ☐ |

Please list any serious medical condition(s) that you have ever had.
_____

## Dental History

Now or in the past, have you had:

| | Yes | No |
|---|---|---|
| Baby Teeth Removed That Were Not Loose | ☐ | ☐ |
| Bleeding Gums/Bad Taste/Bad Odor | ☐ | ☐ |
| Difficulty Breathing/Snoring | ☐ | ☐ |
| Excessive Food Impaction Between Teeth | ☐ | ☐ |
| Extra or Missing Teeth | ☐ | ☐ |
| Gum Problems/Gum Treatment | ☐ | ☐ |
| Jaw Clenching/Clicking/Locking | ☐ | ☐ |
| Pain in Jaw/Ringing in Ears | ☐ | ☐ |
| Sensitive Teeth | ☐ | ☐ |
| Speech Problems | ☐ | ☐ |
| Soreness of Face Muscles | ☐ | ☐ |
| Thumb/Finger Sucking | ☐ | ☐ |
| Tongue Thrusting | ☐ | ☐ |
| Tooth Grinding | ☐ | ☐ |

What is your primary concern?_____
_____
_____

## Patients Under 18 Only

Does the patient brush his/her teeth
conscientiously? Yes☐ No ☐

Is the patient sensitive or self-conscious
about teeth? Yes☐ No ☐

Does the patient have learning disabilities
or need extra help with instructions? Yes☐ No ☐

Please Explain_____
_____
_____
_____
_____

## Thank You For Completing Your Patient Information

I have read and understand the above questions. I will not hold my orthodontist or any member or his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.
I understand that where appropriate a credit report may be obtained.

_____ _____
Signature Date