Medical History Questionaire

FULL NAME: _____

The following information is required to enable us to provide you with the best possible orthodontic care. All information is strictly private, and is protected by doctor-patient confidentiality. The orthodontist will review the questions and explain any that you do not understand. Please fill out the entire form.

Is the patient currently under the care of a physician? ❑ YES ❑ NO

If yes, for what reason? _____

_____

Physician's name: _____

Date of last medical checkup: _____

History of major illness or ever hospitalized? ❑ YES ❑ NO

If yes, please describe: _____

_____

_____

Has the patient been treated for or had any of the following? (please circle)

rheumatic feve	rheumatic heart disease	asthma
autism	diabetes	high blood pressure
tuberculosis	nervous disorder	radiation therapy
arthritis	artificial joint	kidney or liver problems
heart disease	heart murmur	hepatitis
cancer	bleeding problems	epilepsy
HIV positive	sexually transmitted disease	learning disability
osteoporosis	bisphosphonates	

other _____

Any problems with dental anesthetic, drugs or procedures done by a dentist? ❑ YES ❑ NO

Any sensitivities or allergies? ❑ YES ❑ NO

If yes, please describe: _____

_____

Currently taking any medications? ❑ YES ❑ NO

If yes, please list (include dosage): _____

_____

_____

_____

Any shortness of breath or pains in the chest? ❑ YES ❑ NO

Any snoring or sleeping problems? ❑ YES ❑ NO

Any family history of snoring? ❑ YES ❑ NO

Do you smoke or chew tobacco products? ❑ YES ❑ NO

For women: Are you pregnant? ❑ YES ❑ NO

Are you in good health? ❑ YES ❑ NO

Signature of patient: _____

Date: _____

Signature of person filling out form: _____

Orthodontist's signature: _____

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