



# Medical History Questionnaire

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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