dana orthodontics

MEDICAL HISTORY FORM

Name:_____ Date:_____

Date of Birth: _____Age:_____ Sex: M / F Height:_____Weight: _____

Please circle yes or no, whichever applies, for the following questions. Your answers are for our records only and will be considered confidential.

1. Are you in good health? ..... Yes No
2. Has there been any change in your health in the past year? ..... Yes No
3. My last physical exam was on _____/_____/_____
4. Are you now under the care of a physician? ..... Yes No
   If so, for what condition? _____
5. The name and address of my physician is:_____
   _____
   _____
6. Have you had any serious illness, significant operation or hospitalization within the past 5 years? ..... Yes No
7. Have you had tonsils and/ or adenoids evaluated and/ or removed ..... Yes No
8. Have you ever been diagnosed with a craniofacial syndrome or other syndrome? ..... Yes No
   If so, please list _____
9. Are you taking any medicine(s) including non-prescription, homeopathic or "natural" remedies including diet pills ..... Yes No
   If so, please list_____
10. Do you have or have you had any of the following diseases or problems?
    a. Damaged heart valves, artificial valves or heart murmur ..... Yes No
    b. Rheumatic Heart Disease ..... Yes No
    c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition ..... Yes No
       1. Chest pain upon exertion? ..... Yes No
       2. Shortness of breath after mild exercise? ..... Yes No
       3. Do your ankles swell? ..... Yes No
    d. Allergies ..... Yes No
    e. Sinus trouble ..... Yes No
    f. Asthma or hay fever ..... Yes No
    g. Fainting spells or seizures ..... Yes No
    h. Diabetes ..... Yes No
    i. Hepatitis, jaundice or liver disease ..... Yes No
    j. Frequent or recurring mouth sores ..... Yes No
    k. Thyroid problems ..... Yes No
    l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
    m. Arthritis or painful, swollen joints including jaw joint (TMJ) ..... Yes No
    n. Stomach ulcer or hyperacidity ..... Yes No
    o. Kidney trouble ..... Yes No
    p. Tuberculosis ..... Yes No
    q. Persistent cough or cough that produces blood ..... Yes No
    r. Persistent swollen neck glands ..... Yes No
    s. Low blood pressure ..... Yes No
    t. Epilepsy or neurological disorder ..... Yes No
    u. Are you taking vitamins or homeopathic remedies ..... Yes No
    v. Cancer ..... Yes No
    w. Any disease, drug or transplant operation that has depressed your immune system ..... Yes No
11. Have you had abnormal bleeding? ..... Yes No
    a. Have you ever required a blood transfusion? ..... Yes No
12. Do you have any blood disorder such as anemia? ..... Yes No
13. Have you ever had treatment for a tumor or growth? ..... Yes No
14. Are you currently taking or have you ever taken bisphosphonates (i.e. Fosamax, Boniva etc) ..... Yes No

Initials and Date _____

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15. Are you allergic to or have you had a reaction to:
    a. Local anesthetics Yes No
    b. Penicillin or antibiotics ..... Yes No
    c. Sulfa drugs ..... Yes No
    d. Barbiturates or sleeping pills ..... Yes No
    e. Aspirin ..... Yes No
    f. Iodine ..... Yes No
    g. Codeine or other narcotics ..... Yes No
    h. Latex or rubber products ..... Yes No
    i. Other ..... Yes No
13. Have you had any serious trouble associated with previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
14. Do you have any other condition or disease you think the doctor should know about? ..... Yes No
    If so, explain: _____
15. Are you wearing contact lenses? ..... Yes No
16. Are you wearing removable dental appliances? ..... Yes No
17. Do you wish to talk with the doctor privately about anything? ..... Yes No

Females

18. Have you started menstruation (reached puberty)? ..... Yes No
19. Are you pregnant or trying to become pregnant? ..... Yes No

Chief Dental Complaint: _____
_____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I have had the opportunity to discuss my heath history with my doctor.

Date: _____ Patient (or Responsible Party's) Signature: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Date: _____ Doctor's Signature: _____

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____