

HEALTH HISTORY

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand the question)

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now?
For what? _____
Date of last medical exam? _____ Date of last dental appt? _____
5. Yes No Are you in pain now?
6. Yes No Has patient ever sucked thumb of fingers?
Until what age? _____ **Telephone**
7. Yes No Does patient clench or grind teeth?
8. Yes No Does patient have pain or clicking upon closing the mouth? Dentist: _____
9. Yes No Has any member of the family had orthodontic treatment? Physician: _____
Who? _____
10. Yes No Has the patient been examined by an orthodontist before?
By Dr. _____ Date _____

II. HAVE YOU EXPERIENCED?

- | | | | |
|------------|------------------------------------------|------------|------------------------|
| 11. Yes No | Chest pain (angina)? | 22. Yes No | Dizziness? |
| 12. Yes No | Swollen ankles? | 23. Yes No | Ringing in ears? |
| 13. Yes No | Shortness of breath, asthma? | 24. Yes No | Headaches? |
| 14. Yes No | Recent weight loss, fever, night sweats? | 25. Yes No | Fainting spells? |
| 15. Yes No | Persistent cough, coughing up blood? | 26. Yes No | Blurred vision? |
| 16. Yes No | Bleeding problems, bruising easily? | 27. Yes No | Seizures? |
| 17. Yes No | Sinus problems? | 28. Yes No | Excessive thirst? |
| 18. Yes No | Difficulty swallowing? | 29. Yes No | Frequent urination? |
| 19. Yes No | Diarrhea, constipation, blood in stools? | 30. Yes No | Dry mouth? |
| 20. Yes No | Frequent vomiting, nausea? | 31. Yes No | Jaundice? |
| 21. Yes No | Difficulty urinating, blood in urine? | 32. Yes No | Joint pain, stiffness? |

III. DO YOU HAVE OR HAVE YOU HAD?

- | | | | |
|------------|-------------------------------------------------------|------------|-----------------------------|
| 33. Yes No | Heart disease? | 44. Yes No | AIDS or ARC? |
| 34. Yes No | Heart attack, heart defects? | 45. Yes No | Tumors, cancer? |
| 35. Yes No | Heart murmur? | 46. Yes No | Arthritis, rheumatism? |
| 36. Yes No | Rheumatic fever? | 47. Yes No | Latex sensitivity? |
| 37. Yes No | Stroke, hardening of arteries? | 48. Yes No | Skin diseases? |
| 38. Yes No | High blood pressure? | 49. Yes No | Anemia? |
| 39. Yes No | TB, emphysema, other lung diseases? | 50. Yes No | VD (syphilis or gonorrhea)? |
| 40. Yes No | Hepatitis, other liver disease? | 51. Yes No | Herpes? |
| 41. Yes No | Stomach problems, ulcers? | 52. Yes No | Kidney, bladder disease? |
| 42. Yes No | ALLERGIES: to drugs, foods, medications, anesthetics? | 53. Yes No | Thyroid, adrenal disease? |
| 43. Yes No | Family history of diabetes, heart problems, tumors? | 54. Yes No | Diabetes? |

IV. DO YOU HAVE OR HAVE YOU HAD?

- | | | | |
|------------|-------------------------|------------|---------------------|
| 55. Yes No | Psychiatric care? | 60. Yes No | Hospitalization? |
| 56. Yes No | Radiation treatments? | 61. Yes No | Blood transfusions? |
| 57. Yes No | Chemotherapy? | 62. Yes No | Surgeries? |
| 58. Yes No | Prosthetic heart valve? | 63. Yes No | Pacemaker? |
| 59. Yes No | Diet medication? | 64. Yes No | Contact lenses? |

V. ARE YOU TAKING?

- | | | | |
|------------|------------------------------------|------------|----------------------|
| 65. Yes No | Recreational drugs? | 67. Yes No | Tobacco in any form? |
| 66. Yes No | Drugs, medicines, (incl. aspirin)? | 68. Yes No | Alcohol? |

Please list _____, _____, _____
_____, _____, _____

VI. WOMEN ONLY:

- | | | | |
|------------|----------------------------------------------|------------|-----------------------------|
| 69. Yes No | Are you or could you be pregnant or nursing? | 70. Yes No | Taking birth control pills? |
|------------|----------------------------------------------|------------|-----------------------------|

VII. ALL PATIENTS:

71. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my orthodontist of any change in my health and/or medication.

Patient's/ Guardian Signature _____ Date _____

RECALL REVIEW:

1. Patient's/ Guardian Signature _____ Date _____
2. Patient's/ Guardian Signature _____ Date _____