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? ____________
7. Yes No Does patient clench or grind teeth?
8. Yes No Does patient have pain or clicking upon closing the mouth?
9. Yes No Has any member of the family had orthodontic treatment?
   Who? ____________________
10. Yes No Has the patient been examined by an orthodontist before?
    By Dr. ____________ Date ____________

Telephone

Dentist: ____________

Physician: ____________

II. HAVE YOU EXPERIENCED?

No.				No.			
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?

No.				No.			
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?

No.				No.			
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?

No.				No.			
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 ____________