Medical History Form

Name:_____

Do you have, or have you ever had, any of the following medical conditions (circle if yes):

Heart problems; Heart Murmur; Blood pressure problem; Asthma/breathing problem; Allergies; Diabetes/Endocrine problem; Immune system problem; Bleeding disorder; Anemia; Arthritis; Liver problem/hepatitis; Neurological/Mood disorder

Details about circled conditions

_____
_____
_____
_____
_____

Are you currently taking any medications (Please list)_____
_____
_____

Do you have, or have you ever had, any of the following dental conditions (circle if yes):

Cavities; Gum disease/periodontal disease; TMJ problems (clicking or pain in your jaw joints); Teeth sensitive to hot/cold; Teeth extracted; Wisdom teeth problems; Speech problems; Abnormal swallowing; Sucking habit (thumb sucking, nail biting, etc.); Dead teeth/root canal treatments; jaw fractures

Details about circled conditions_____
_____
_____

How often do you brush: _____ Floss: _____
What is your primary concern? Why are you here?

_____
_____
_____

I have read and I understand the above questions. I will not hold my orthodontist or any member or his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.
Signed Patient:_____

Date:_____