

Medical Health History

PATIENT NAME: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____

DATE OF LAST EXAM: _____ MEDICAL ALERT: _____

- | | |
|--|---|
| <p>1. Are you under medical treatment now?
 <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness?
 <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Are you taking any medicine? If yes, what medication(s) are you taking?

 _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>5. Are you wearing contact lenses?
 Comments: _____
 _____</p> | <p>6. Are you allergic to or have you had any reactions to the following?
 YES NO
 <input type="checkbox"/> <input type="checkbox"/> Local Anesthetics
 <input type="checkbox"/> <input type="checkbox"/> Aspirin
 <input type="checkbox"/> <input type="checkbox"/> Sedatives
 <input type="checkbox"/> <input type="checkbox"/> Iodine</p> <p>7. WOMEN ONLY: YES NO
 a) Are you pregnant or think you may be pregnant? <input type="checkbox"/> <input type="checkbox"/>
 b) Are you nursing? <input type="checkbox"/> <input type="checkbox"/>
 c) Are you taking birth control pills? <input type="checkbox"/> <input type="checkbox"/></p> |
|--|---|

8. Do you have or have you had any of the following?

- | | | |
|--|--|---|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
 <input type="checkbox"/> <input type="checkbox"/> Heart Attack
 <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
 <input type="checkbox"/> <input type="checkbox"/> Swollen Ankles
 <input type="checkbox"/> <input type="checkbox"/> Fainting/Seizures
 <input type="checkbox"/> <input type="checkbox"/> Asthma
 <input type="checkbox"/> <input type="checkbox"/> Low Blood Pressure
 <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Convulsions
 <input type="checkbox"/> <input type="checkbox"/> Leukemia
 <input type="checkbox"/> <input type="checkbox"/> Diabetes
 <input type="checkbox"/> <input type="checkbox"/> Kidney Diseases
 <input type="checkbox"/> <input type="checkbox"/> AIDS of HIV Infection
 <input type="checkbox"/> <input type="checkbox"/> Thyroid Problem</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease
 <input type="checkbox"/> <input type="checkbox"/> Cardiac Pacemaker
 <input type="checkbox"/> <input type="checkbox"/> Heart Murmur
 <input type="checkbox"/> <input type="checkbox"/> Angina
 <input type="checkbox"/> <input type="checkbox"/> Frequently Tired
 <input type="checkbox"/> <input type="checkbox"/> Anemia
 <input type="checkbox"/> <input type="checkbox"/> Emphysema
 <input type="checkbox"/> <input type="checkbox"/> Cancer
 <input type="checkbox"/> <input type="checkbox"/> Arthritis
 <input type="checkbox"/> <input type="checkbox"/> Joint Replacement or Implant
 <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Jaundice
 <input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease
 <input type="checkbox"/> <input type="checkbox"/> Stomach Troubles/Ulcers</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pains
 <input type="checkbox"/> <input type="checkbox"/> Easily Winded
 <input type="checkbox"/> <input type="checkbox"/> Stroke
 <input type="checkbox"/> <input type="checkbox"/> Hay Fever/Allergies
 <input type="checkbox"/> <input type="checkbox"/> Tuberculosis
 <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy
 <input type="checkbox"/> <input type="checkbox"/> Glaucoma
 <input type="checkbox"/> <input type="checkbox"/> Recent Weight Loss
 <input type="checkbox"/> <input type="checkbox"/> Liver Disease
 <input type="checkbox"/> <input type="checkbox"/> Heart Trouble
 <input type="checkbox"/> <input type="checkbox"/> Respiratory Problems
 <input type="checkbox"/> <input type="checkbox"/> Other _____</p> |
|--|--|---|

COMMENTS: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ **DATE:** _____
 PATIENT, PARENT OR GUARDIAN

SIGNATURE-Michael Parker, DDS, MS: _____ **DATE:** _____

*****FILL OUT FORM ON OTHER SIDE →**

Patient Dental History

PATIENT NAME _____

Patient's Dentist: _____ Date of Last Dental Visit: _____

Any X-Rays taken? NO YES: what type? _____

Dental Specialists (Orthodontist, Periodontist, Oral Surgeon, etc..) who treated you (give names, treatments & dates): _____

Chief Orthodontic Complaint (Reason for this visit): _____

How many times per day do you brush your teeth? 1 2 3+

How many times per day do you floss 0 1 +2

1. Any injuries to face, mouth or teeth? -----

YES NO

If yes, explain _____

2. Ever sucked thumb or finger(s)? -----

Until what age _____

3. Speech problems?-----

4. Breathes predominately through the mouth?-----

5. Any missing or extra **permanent** teeth?-----

6. Any teeth removed by the dentist-----

If yes which _____

7. Clench or grinds teeth?-----

8. Congenital abnormalities?-----

9. Had psychological counseling?-----

10. Tonsil or adenoids removed?-----

If yes at what age? _____

11. Would the patient mind wearing braces?-----

12. Difficulty/apprehensive toward dental visits?-----

13. Has patient reached puberty?-----

If yes, at what age _____

14. Frequent headaches?-----

15. Are your teeth sensitive to hot or cold liquids or food?

16. Do you feel pain in any of your teeth?-----

17. Have you experienced any of the following problems

in your jaw? a) Clicking-----

b) Difficulty in opening or closing---

c) Difficulty in chewing?-----

18. Approximate growth last 6 months _____

19. Height Patient _____ Mother _____ Father _____

20. Patient's mouth resembles: Mother Father

Comments: _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____

PATIENT, PARENT OR GUARDIAN

DATE

SIGNATURE- Michael Parker, DDS, MS: _____

DATE