

# Medical Questionnaire

Welcome to our office. We appreciate the confidence you place with us to provide orthodontic services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Name of your physician \_\_\_\_\_ Date of last visit to physician \_\_\_\_\_

Name of general dentist \_\_\_\_\_ Date of last visit to dentist \_\_\_\_\_

## MEDICAL HEALTH HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems	_____	Allergy Problems	_____
Chest pain	_____	Hay fever	_____
Shortness of breath	_____	Sinus problems	_____
Blood pressure problem	_____	Skin rashes	_____
Heart murmur	_____	Taking allergy medication	_____
Heart valve problem	_____	Asthma	_____
Rheumatic fever	_____		
Pacemaker	_____	Intestinal Problems	_____
Artificial heart valve	_____	Ulcers	_____
		Weight loss or gain	_____
Blood Problems	_____	Special diet	_____
Easy bruising	_____	Constipation	_____
Frequent nose bleeds	_____		
Abnormal bleeding	_____	Bone or Joint Problems	_____
Blood disease	_____	Arthritis	_____
		Back or neck pain	_____
Fainting Spells, Seizures, or Epilepsy	_____	Joint replacement (e.g. total hip)	_____
Diabetes	_____	Tuberculosis or other respiratory disease	_____
Urinate more than 6 x day	_____		
Thirsty or mouth is dry most times	_____	Cancer/Tumor	_____
Family history of diabetes	_____		
		Do you drink?	_____
Hepatitis, Jaundice, or Liver Trouble	_____	If so, how much? _____	
Herpes	_____	Do you smoke?	_____
		If so, how much? _____	
HIV-Positive/AIDS	_____		
		Glaucoma	_____
		Do you wear contact lenses?	_____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING?

Local anesthetics ("Novocaine")	_____
Penicillin or other antibiotics	_____
Sulfa drugs	_____
Barbiturates	_____
Aspirin	_____
Codeine	_____

WOMEN:

Are you taking contraceptives or other hormones?	_____
Are you pregnant?	_____
Expected delivery date _____	
Have any of your babies weighed more than nine pounds?	_____
Have you reached menopause?	_____

DURING THE PAST 12 MONTHS HAVE YOU TAKEN ANY OF THE FOLLOWING?

Antibiotics or sulfa drugs	_____
Anticoagulants	_____
High blood pressure medicine	_____
Tranquilizers	_____
Insulin, Orinase, or similar drug	_____
Aspirin	_____
Digitalis or drugs for heart trouble	_____
Nitroglycerin	_____
Cortisone (steroids)	_____
Other	_____
Other	_____