

Patient Medical History

www.midwestorthodontics.com

| Patient Name: | Date of Birth: _ | Gender: | Age: | |
|--|-------------------------------------|---------------------------------------|---------------------------------------|--|
| Preferred Pharmacy: Ad | dress: | | Zip code: | |
| Although Dental personnel primarily treat the area in and problems you may have, or medications you may be taking you for answering the following questions completely and a | g, could have an important interr | | | |
| | General Medical Histo | ry | | |
| Are you under a physician's care now? | Ves No If Ves Ples | ese Evnlain: | | |
| Have you ever had a serious head/neck injury? | | No If Yes, Please Explain: | | |
| Are you taking any medications/pills/drugs? | | s No If Yes, Please List: | | |
| Have you been hospitalized or had a major operation? | | se Explain: | | |
| Have you taken, or do you take, Phen-Fen or Redux? | | | | |
| Are you on a special diet? | | | | |
| Do you use tobacco products? | | ong, # packs/day: | | |
| Do you use controlled substances? | | mg, " paokoraay. | | |
| For Women: Are you: Pregnant/Trying to get pregnant | | | | |
| To tronien: 7 to you 1 toghand 11 ying to get prognan | runingruning | | | |
| Are you Allergic to any of the following: | | | | |
| Aspirin Penicillin Codeine Acryli | c Metal Latex | _ Local Anesthetics Other: _ | | |
| Do you have, or have you ever had, any of the following | | | | |
| AIDS/HIV PositiveChest Pains | Frequent Headaches | Irregular Heartbeat | Scarlet Fever | |
| Alzheimer's DiseaseCold Sores/Fever Blister Anaphylaxis Congenital Heart Disord | | Kidney Problems Leukemia | Shingles Sickle Cell Disease | |
| Anemia Convulsions | Hay Fever | Liver Disease | Sinus Trouble | |
| AnginaCortisone Medicine | Heart Attack/Failure | Low Blood Pressure | Spina Bifida | |
| Arthritis/GoutDiabetes | Heart Murmur | Lung Disease | Stomach/Intestinal Diseas | |
| Artificial Heart ValveDrug Addiction | Heart Pace Maker | Mitral Valve Prolapse | Stroke | |
| AsthmaEmphysema | Hemophilia | Parathyroid Disease | Thyroid Disease | |
| Blood DiseaseEpilepsy or Seizures Blood Transfusion Excessive Bleeding | Hepatitis A Hepatitis B or C | Psychiatric Care Radiation Treatments | Tonsillitis Tuberculosis | |
| Breathing ProblemExcessive Dieeding | Herpes | Recent Weight Loss | Tumors or Growths | |
| Bruise EasilyFainting Spells/Dizzines | | Renal Dialysis | Ulcers | |
| CancerFrequent Cough | Hives or Rash | Rheumatic Fever | Venereal Disease | |
| ChemotherapyFrequent Diarrhea | Hypoglycemia | Rheumatism | Yellow Jaundice | |
| Have you ever had a serious illness not listed above? If Ye | es nlease explain: | | | |
| That's you are mad a serious infloss flot flotou above. If the | o, prodec explain: | | · · · · · · · · · · · · · · · · · · · | |
| General Health History Comments: | | | | |
| | Dental History | | | |
| When was your last dental exam? | | last dental x-rays taken? | | |
| How often do you brush? Times daily How often | | • | | |
| Have you ever had braces/orthodontic treatment? Yes | | | | |
| Have you ever been treated for periodontal disease? | | | | |
| Have you ever had injuries to your teeth, face or jaw? | | | | |
| That's year even had injuries to your tooth, face of jaw. | 100 140 11 yes, please expli | MIII. | | |
| Do you experience, or have you experienced in the pas | t, any of the following: | | | |
| Bad BreathBleeding Gums | Blisters on Mouth | Broken Fillings/Teeth | Clicking Jaw | |
| DenturesDental Anxiety | Difficulty Opening/Closi | | Dry Mouth | |
| Ear PainJaw Pain | Loose Teeth Sensitivity – Sweets | Missing Teeth Sensitivity – Pressure | Mouth Sores Swollen Gums | |
| Sensitivity – Cold Sensitivity – Hot | | | | |

Signature of Patient or Parent/Guardian: ______ Date: _____