ORTHODONTICS
in the highlands

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PATIENT MEDICAL HISTORY

DATE: _____

Patient Name: _____ _____
Last First MI (Nickname)

Have you ever had any of the following? Please check those that apply:

- ☐ **AIDS**
- ☐ **Excessive Bleeding**
- ☐ **Anemia**
- ☐ **Arthritis**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Dizziness**
- ☐ **Epilepsy**
- ☐ **Allergies** (List Below)

_____
_____

- ☐ **Fainting**
- ☐ **Glaucoma**
- ☐ **Growths**
- ☐ **Hay Fever**
- ☐ **Head Injuries**
- ☐ **Heart Disease**
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **Jaundice**
- ☐ **Kidney Disease**
- ☐ **Liver Disease**
- ☐ **Mental Disorders**
- ☐ **Nervous Disorders**

- ☐ **Pacemaker**
- ☐ **Pregnancy**
  Months Pregnant_____
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems**
- ☐ **Rheumatic Fever**
- ☐ **Rheumatism**
- ☐ **Sinus Problems**
- ☐ **Stomach Problems**
- ☐ **Stroke**
- ☐ **Tuberculosis**
- ☐ **Tumors**
- ☐ **Ulcers**
- ☐ **Venereal Disease**

☐ **Girls only: Date of first menstruation** _____

Have you ever had any complication following dental treatment? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Have you been admitted to a hospital during the past two years? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Are you now under the care of a physician? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

Do you have any health problems that need further clarification? ☐ **Yes** ☐ **No**
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform your office at the next appointment without fail.

Signature of patient, parent or guardian: _____ **Date:** _____