MEDICAL HISTORY

Patient Name _____

For the patient named on this form: Place a check in the " yes" (Y) column for each condition which is currently or has ever been applicable. Otherwise place a check in the " no" (N) column.

	Y	N		Y	N
Previous orthodontic treatment			Frequent shortness of breath		
Dental problems other than routine care			Sinus trouble		
Tooth extractions (removal)			Smoker or smokeless tobacco		
Negative reaction to dental care			Seasonal allergy		
Injury to face or mouth			Allergy to medication		
Jaw pain			Hives or rash		
Difficulty moving jaw			Other allergy		
Difficulty chewing			Mumps		
Difficulty swallowing			Chickenpox		
Gag easily			Venereal disease		
Suck your thumb or fingers			Fainting or dizziness		
Play a musical instrument			Thyroid or other endocrine disorder		
Tonsils or adenoids removed			Frequent headaches		
Speech impairment			Epilepsy or seizures		
Heart condition			Emotional or nervous disorder		
Congenital heart defect			Psychiatric care		
Rheumatic fever			Severe weight loss or gain		
Chest pains			Diabetes		
Swollen ankles			Kidney or liver disease		
Stroke			Ulcers		
Bleeding problems			Scarlet fever		
High or low blood pressure			Ear pain or infection		
Anemia			Hearing impairment		
Artificial valves or joints			Glaucoma		
Blood transfusion			Arthritis		
Compromised immune system			Cancer or tumor		
HIV or AIDS			Major surgery		
Lung Disease			Birth defects		
Asthma			Other recurrent illness		
Bronchitis			Taking *any* medications or supplements		
Emphysema			**FEMALES ONLY:**		
Pneumonia			Reached menses (first period)		
Tuberculosis			In menopause		
Frequent colds or sore throat			Using birth control medication		
Persistent cough			Pregnant		

HISTORY GIVEN BY: _____ DATE: _____

Doctor's Notes:

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Medical alerts to be entered in e-chart? □ Y □ N _____