Pattison ORTHODONTICS

MEDICAL HISTORY

Date_____

1. Is the patient's general health good at this time? ☐ YES ☐ NO
2. What is the name of the General Dentist? Date of last dental cleaning:_____
3. What is the name of the family physician? Date of last physical:_____
4. Is the patient under the care of a physician at this time? ☐ YES ☐ NO
   Explain_____
5. Is the patient taking any medication ☐ YES ☐ NO
   Explain_____
6. Is the patient allergic to any medication (Penicillin, Sulfa, etc.) ☐ YES ☐ NO
   Name_____
7. Has the patients had tonsils or adenoids removed? ☐ YES ☐ NO
   Age_____
8. Has the patient ever had a serious illness or been hospitalized? ☐ YES ☐ NO
   Explain_____
9. Does the patient have any special problems not listed? ☐ YES ☐ NO
   Explain_____
10. Has the patient ever been advised by their physician to take an antibiotic prior to dental treatment? ☐ YES ☐ NO
    If yes, antibiotic name and method:_____
11. What is the patient's approximate height?_____ Weight?_____
12. Has the patient shown signs of increased growth recently? ☐ YES ☐ NO
13. Has the patient reached puberty? ☐ YES ☐ NO
    Girls - started menstruating? ☐ YES ☐ NO
    Boys - voice changed? ☐ YES ☐ NO
14. WOMEN: Are you pregnant of considering pregnancy during the next two years? ☐ YES ☐ NO
    Are you nursing?
    Are you currently taking medication for birth control? ☐ YES ☐ NO
15. Father's present height?_____ Older' brother's present height?_____
    Mother's present height?_____ Older sister's present height?_____

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

- ☐ Endocarditis
- ☐ Heart Condition
- ☐ Heart Pacemaker
- ☐ Heart Angina
- ☐ Heart Attach (coronary)
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Disease
- ☐ Artificial Heart Valve
- ☐ Heart Surgery: date_____
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Prosthetic (artificial) Joint
- ☐ X-Ray/Radiation (cancer) Therapy
- ☐ AIDS or H.I.V. Positive
- ☐ Diabetes
- ☐ Respiratory Lung Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis (type)_____
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Herpes (oral-cold sores)
- ☐ Blood Disorder/Bleed Problems
- ☐ Inflammatory Rheumatism
- ☐ Arthritis
- ☐ Ulcers
- ☐ Stroke
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Fainting Spells
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Psychiatric Treatment
- ☐ Drug Addiction
- ☐ Headaches
- ☐ Earaches
- ☐ Jaw Clicking
- ☐ Allergies
- ☐ Jaw Pain
- ☐ Tonsillitis
- ☐ Emotional Problems
- ☐ Other_____
- ☐ _____

MEMO:
_____
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I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION NOT DISCLOSED.

SIGNATURE OF PATIENT OR PARENTS OR GUARDIAN

_____

SIGNATURE OF DENTIST

_____

Today's Date:_____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

Update_____Initial_____

CONFIDENTIAL (for record and pretreatment evaluation)