General Medical / Dental History

Patient Name: _____ Date: _____

General dentist's name: _____Last seen? _____
Reason for the appointment? _____
How often does patient see their general dentist per year? _____

Other than routine cleaning and check ups, is the patient currently undergoing any dental procedures?
No _____ Yes _____ Please explain: _____

Has patient ever experienced a reaction to dental procedures? No _____ Yes _____
If yes, what reaction? _____

Is patient currently taking medications? No _____ Yes _____
If yes, list medications: _____

Does patient need to take antibiotics prior to receiving dental procedures? No _____ Yes _____

Is patient allergic to any medications? No _____ Yes _____
If yes, list medications _____

Does patient have allergies? (i.e. food, seasonal, etc.) No _____ Yes _____
If yes, what type of allergy? _____
Medications (include non-prescription drugs): _____

Does patient have asthma? No _____ Yes _____
List medications taken for asthma _____

Are Tonsils present? No _____ Yes _____ Date removed _____
Are Adenoids present? No _____ Yes _____ Date removed _____

Female: Have menses (monthly period) begun? No _____ Yes _____
Month/Year menses began _____ Gynecological problems? Explain _____
Pregnant? No _____ Yes _____ Due Date_____

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1. Arthritis: No _____ Yes _____
Rheumatoid _____ Gout _____ Osteoarthritis _____ Osteoporosis _____Other _____
Explain: _____Medications: _____

2. Artificial Implants: No _____ Yes _____
Joint Prosthesis _____ Pacemaker _____ Cardiac Valve _____ Other _____
Explain: _____Medications: _____

3. Blood Disease: No _____ Yes _____
Bleeds easily _____ Anemia _____ Leukemia _____ Other _____
Explain: _____Medications: _____

4. Endocrine Disease: No _____ Yes _____
Diabetes _____ Thyroid Dysfunction _____ Other _____
Explain: _____Medications: _____

5. Eye Disease: No ____ Yes____ Glaucoma _____Herpes _____ Ocular _____ Other _____
Explain: _____Medications: _____

6. Headache: No _____ Yes _____
Tension _____ Migraine _____ Unclassified _____ Other _____
Explain: _____Medications: _____

7. Liver Disease: No _____ Yes _____
Hepatitis _____ Cirrhosis of the liver _____ Other _____
Explain: _____Medications: _____

8. Lung Disease: No _____ Yes _____
Asthma _____ Emphysema _____ Cancer _____ Other _____
Explain: _____Medications: _____

9. Muscle Dysfunction: No _____ Yes _____
Muscular Stretching _____ Muscular Dystrophy _____ Frequent muscle contractions _____
Explain: _____Medications: _____

10. Neurological Disorders: No _____ Yes _____
Epilepsy _____ Paralysis _____ Apoplexia _____ Neurology _____ Multiple Sclerosis _____
Parkinson Disease _____ Other _____
Explain: _____Medications: _____

11. Digestive Disease: No _____ Yes _____
Ulcer _____ Gastritis _____ Colitis _____ Other _____
Explain: _____Medications: _____

12. HIV Disease: No _____ Yes _____
ARC _____ HIV positive test _____ Other _____
Explain: _____Medications: _____

13. Other Conditions: No _____ Yes _____
ADD _____ ADHD_____ Mental disorders _____ Sexual disease _____ Cancer _____
Chemotherapy _____ Other _____ Explain: _____
Medications: _____

14. Cardiovascular Disease: No _____ Yes _____
Coronary artery problems _____ High blood pressure _____ Cardiac murmur _____
Explain: _____Medications: _____

15. Urinary Disease: No _____ Yes _____
Kidney disease _____ Bladder infection _____ Other _____
Explain:_____ Medications: _____

16. Is the patient currently receiving, or has the patient ever received speech therapy?
Yes ____ No ____ Explain: _____

Patient/parental concerns: _____
Previous orthodontic experience: _____

To the best of my knowledge, I have answered the questions truthfully and accurately. I feel there is no other dental/medical history that I feel would be detrimental to receiving orthodontic treatment. I also understand it is my responsibility to make Orthodontists Associates aware of any changes to this dental/medical history.

_____

Signature of patient/guardian (if minor) Date