

# CONFIDENTIAL

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### FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Name of Patient's Physician \_\_\_\_\_ Physician's Phone No. \_\_\_\_\_  
Physician's Address \_\_\_\_\_

*For the following questions circle yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.*

1. Are you in good health? \_\_\_\_\_ **yes no dk/u**
  2. Has there been any change in health in the last year? \_\_\_\_\_ **yes no dk/u**
  3. Date of last physical exam \_\_\_\_\_
  4. Are you now under medical care? \_\_\_\_\_ **yes no dk/u**  
If so, for what? \_\_\_\_\_
  5. Have you ever had a serious illness or operation? \_\_\_\_\_ **yes no dk/u**  
If so, explain \_\_\_\_\_
  6. Do you have or have you ever had any of the following?
    - A. Rheumatic fever or rheumatic heart disease \_\_\_\_\_ **yes no dk/u**
    - B. Congenital heart disease \_\_\_\_\_ **yes no dk/u**
    - C. Cardiovascular disease (heart trouble, heart murmur, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) \_\_\_\_\_ **yes no dk/u**
    - D. Allergy or hay fever \_\_\_\_\_ **yes no dk/u**
    - E. Asthma \_\_\_\_\_ **yes no dk/u**
    - F. Hives or skin rash \_\_\_\_\_ **yes no dk/u**
    - G. Fainting spells \_\_\_\_\_ **yes no dk/u**
    - H. Diabetes \_\_\_\_\_ **yes no dk/u**
    - I. Hepatitis, jaundice or liver disease \_\_\_\_\_ **yes no dk/u**
    - J. Inflammatory rheumatism (painfully swollen joints) \_\_\_\_\_ **yes no dk/u**
    - K. Arthritis \_\_\_\_\_ **yes no dk/u**
    - L. Stomach ulcers \_\_\_\_\_ **yes no dk/u**
    - M. Kidney trouble \_\_\_\_\_ **yes no dk/u**
    - N. Tuberculosis \_\_\_\_\_ **yes no dk/u**
    - O. Persistent cough or cough up blood \_\_\_\_\_ **yes no dk/u**
    - P. AIDS or HIV Positive \_\_\_\_\_ **yes no dk/u**
    - Q. Sexually transmitted disease \_\_\_\_\_ **yes no dk/u**
    - R. Epilepsy or seizure disorder \_\_\_\_\_ **yes no dk/u**
    - S. Artificial joint prosthesis \_\_\_\_\_ **yes no dk/u**
    - T. Substance abuse (alcoholism, drug addiction) \_\_\_\_\_ **yes no dk/u**
  7. Do you have pain in chest upon exertion? \_\_\_\_\_ **yes no dk/u**
  8. Are you ever short of breath after mild exercise? \_\_\_\_\_ **yes no dk/u**
  9. Do your ankles swell? \_\_\_\_\_ **yes no dk/u**
  10. Do you get short of breath when you lie down, or do you require extra pillows to sleep? \_\_\_\_\_ **yes no dk/u**
  11. Have you had abnormal bleeding associated with previous surgery, extractions, or accidents? \_\_\_\_\_ **yes no dk/u**
  12. Have you ever required a blood transfusion? \_\_\_\_\_ **yes no dk/u**
  13. Do you have any blood disorders such as anemia, etc? \_\_\_\_\_ **yes no dk/u**
  14. Have you ever had surgery or x-ray treatment for a tumor growth, or other condition? \_\_\_\_\_ **yes no dk/u**
  15. Are you taking any of the following?
    - A. Antibiotics or sulfa drugs \_\_\_\_\_ **yes no dk/u**
    - B. Anticoagulants (blood thinners) \_\_\_\_\_ **yes no dk/u**
    - C. Medicine for high blood pressure \_\_\_\_\_ **yes no dk/u**
    - D. Cortisone or steroids \_\_\_\_\_ **yes no dk/u**
    - E. Tranquilizers \_\_\_\_\_ **yes no dk/u**
    - F. Aspirin or anti-inflammatory agent \_\_\_\_\_ **yes no dk/u**
    - G. Dilantin or other anti-convulsant \_\_\_\_\_ **yes no dk/u**
    - H. Insulin, Tolbutamide, Orinase or similar drug \_\_\_\_\_ **yes no dk/u**
    - I. Digitalis or drugs for heart trouble \_\_\_\_\_ **yes no dk/u**
    - J. Nitroglycerin \_\_\_\_\_ **yes no dk/u**
    - K. Narcotic Analgesic \_\_\_\_\_ **yes no dk/u**
    - L. Birth Control "pill" \_\_\_\_\_ **yes no dk/u**
    - M. Alcohol, Antabuse \_\_\_\_\_ **yes no dk/u**
    - N. Recreational drugs \_\_\_\_\_ **yes no dk/u**
    - O. Any Other? \_\_\_\_\_
  16. Are you allergic to or have you ever reacted adversely to any of the following?
    - A. Local anesthetics (Novocain, etc.) \_\_\_\_\_ **yes no dk/u**
    - B. Penicillin or other antibiotics \_\_\_\_\_ **yes no dk/u**
    - C. Aspirin or anti-inflammatory drugs \_\_\_\_\_ **yes no dk/u**
    - D. Barbiturates, sedatives, or sleeping pills \_\_\_\_\_ **yes no dk/u**
    - E. Narcotic analgesics \_\_\_\_\_ **yes no dk/u**
    - F. Any other? \_\_\_\_\_
  17. Does patient follow directions? \_\_\_\_\_ **yes no dk/u**
  18. Does patient have learning disabilities or need extra help with instructions? \_\_\_\_\_ **yes no dk/u**
  19. Is patient sensitive, self-conscious? \_\_\_\_\_ **yes no dk/u**
  20. Is the patient pregnant? \_\_\_\_\_ **yes no dk/u**  
If so, How far along? \_\_\_\_\_
- If there are any changes later to this history record or medical status, I will so inform this practice. I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.
- \_\_\_\_\_  
Signature of Parent or Guardian Date
- \_\_\_\_\_  
Medical History Update or Changes: Date: Comments: Initials:
- \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_