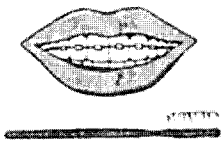

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A Health Oriented Orthodontic Practice

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American Dental Association Standard Medical History

ADA American Dental Association

Patient Name_____

If you are completing this form for another person, what is your name and what is your relationship to that person?_____

Todays Date:_____

In the following questions, circle yes or no, whichever applies. ***Your answers are for our records only and will be considered confidential.***

1. Are you in good health? ..... YES NO
2. Has there been any change in your general health within the past year? ..... YES NO
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... YES NO
   a. If so, what is the condition being treated?_____
5. The name and address of my physician is_____
   _____
   _____
6. Have you had any serious illness or operation? ..... YES NO
   a. If so, what was the illness or operation?_____
7. Have you been hospitalized or had a serious illness within the past five (5) years? ..... YES NO
   a. If so, what was the problem?
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves ..... YES NO
   b. Congenital heart lesions ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES NO
      1) Do you have pain in chest upon exertion? ..... YES NO
      2) Are you ever short of breath after mild exercise? ..... YES NO
      3) Do your ankles swell? ..... YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ..... YES NO
      5) Do you have a cardiac pacemaker? ..... YES NO
   d. Allergy ..... YES NO
   e. Sinus trouble ..... YES NO
   f. Asthma or hay fever ..... YES NO
   g. Hives or a skin rash ..... YES NO
   h. Fainting spells or seizures ..... YES NO
   i. Diabetes ..... YES NO
      1) Do you have to urinate (pass water) more than six times a day? ..... YES NO
      2) Are you thirsty much of the time? ..... YES NO
      3) Does your mouth frequently become dry? ..... YES NO
   j. Hepatitis, jaundice or liver disease ..... YES NO
   k. Arthritis ..... YES NO
   l. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   m. Stomach ulcers ..... YES NO
   n. Kidney trouble ..... YES NO
   o. Tuberculosis ..... YES NO
   p. Do you have a persistent cough or cough up blood? ..... YES NO
   q. Low blood pressure ..... YES NO
   r. Venereal disease ..... YES NO
   s. Other_____

(over)

9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? YES NO
   a. Do you bruise easily? YES NO
   b. Have you ever required a blood transfusion? YES NO
   If so, explain the circumstances
10. Do you have any blood disorder such as anemia? YES NO
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head or neck? YES NO
12. Are you taking any drug or medicine? YES NO

If so, what?_____

13. Are you taking any of the following:
   a. Antibiotics or sulfa drugs YES NO
   b. Anticoagulants (blood thinners) YES NO
   c. Medicine for high blood pressure YES NO
   d. Cortisone (steroids) YES NO
   e. Tranquilizers YES NO
   f. Antihistamines YES NO
   g. Aspirin YES NO
   h. Insulin, tolbutamide (Orinase) or similar drug YES NO
   i. Digitalis or drugs for heart trouble YES NO
   j. Nitroglycerin YES NO
   k. Oral contraceptive or other hormonal therapy YES NO
   l. Other
14. Are you allergic or have you reacted adversely to:
   a. Local anesthetics YES NO
   b. Penicillin or other antibiotics YES NO
   c. Sulfa drugs YES NO
   d. Barbiturates, sedatives, or sleeping pills YES NO
   e. Aspirin YES NO
   f. Iodine YES NO
   g. Codeine or other narcotics YES NO
   h. Latex YES NO
   i. Other YES NO
15. Have you had any serious trouble associated with any previous dental treatment? YES NO
   If so, explain_____

_____

16. Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
   If so, explain_____

_____

17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO

18. Are you wearing contact lenses? YES NO

WOMEN

19. Are you pregnant? YES NO
20. Do you have any problems associated with your menstrual period? YES NO
21. Are you nursing? YES NO

CHIEF DENTAL COMPLAINT:

In case of emergency, whom should we contact?

1. Name:_____ Phone_____
2. Name_____ Phone_____

SIGNATURE OF PATIENT (GUARDIAN, IF MINOR)_____