FAIRFIELD BEACH ORTHODONTICS

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MEDICAL HISTORY FORM

Date: _____

Patient Name _____ Age _____ Sex _____

Date of Birth _____ Phones (Home) _____ (Cell) _____
Month Day Year

Home Address _____
Number Street City State Zip

E-mail address _____

Person Responsible for Payment _____

Patient's School / Work _____ Phone _____

Patient's Dentist _____ Phone _____

Dentist's Address _____

When was the patient's last dental cleaning? _____

Other dentists/dental specialists now being seen: _____ Reason: _____

Significant dental history? _____

Patient's Physician _____ Phone _____

Physician's Address _____

Other physicians/healthcare providers now being seen: _____ Reason: _____

Who referred you to our office? _____

Has any family member been treated orthodontically? _____ Satisfactory / Unsatisfactory? (circle)

What do you wish to gain by treatment? _____

Has the patient had previous orthodontic treatment? Yes / No? (circle)

Please check any disease which the patient has or has had:

___ Birth defects or hereditary problems	___ Immune system problems	___ High or Low Blood Pressure	___ History of eating disorder
___ Bone fractures or major injuries	___ Osteoporosis	___ Heart Defects or Murmur	___ Mental health disturbance or depression
___ Arthritis or joint problems	___ Prosthetic joint	___ Rheumatic Heart Disease	___ Tonsil or adenoid removal
___ Endocrine or thryoid problems	___ Arthritis or joint problems	___ Angina, stroke or heart attack	___ Sexually transmitted diseases
___ Diabetes	___ HIV, AIDS	___ Excessive bleeding or bruising	___ Hepatitis, jaundice, other liver problems
___ Kidney problems	___ Polio, tuberculosis, pneumonia	___ Hemophilia	___ Frequent Headaches or Migraines
___ Cancer, radiation or chemotherapy	___ Fainting spells or seizures	___ Anemia	___ Frequent Ear Aches Colds, Sore Throat
___ Stomach ulcer or acid reflux	___ Neurologic problem	___ Asthma	___ Women: Pregnant or Nursing
___ Allergies? Please list with reaction: _____		___ Any Diseases not listed: _____	

Operations _____ Accidents to head or face _____

Does the patient take any medication? If so, please list. _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Have you ever taken any intravenous or oral medications for bone disorders or cancer such as bisphosphonates? _____

Do you take any pre-medication before any dental procedures? _____

Is the patient a good dental patient? _____

Does the patient desire orthodontic treatment? _____

Do the patient's teeth, mouth or face resemble a relative's? _____

Hobby, sport or instrument which might affect the teeth? _____

Any habits related to the face or teeth (tongue habits, etc.)? _____

Have medical or dental x-rays been taken during the past year? _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in medical or dental health.

Signature _____ Date _____