BIRMINGHAM ORTHODONTICS

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# MEDICAL HISTORY

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____/_____/_____

Overall Medical Health: O Good O Fair O Poor
Are you under a Physician's care now? O Yes O No If YES, please explain: _____
Primary Physician Name: _____ Office Phone # ( ) _____
WOMEN ONLY: Are you pregnant/trying to get pregnant? O Yes O No
Are you allergic to any of the following: O Latex O Penicillin O Codeine O Sulfa O Metal O Adhesives/Glue O Other:_____

Any history of the following: O NO KNOWN HEALTH PROBLEMS

| | | |
|---|---|---|
| O AIDS/HIV Positive | O Convulsions/Epilepsy | O Hepatitis B or C |
| O Anemia | O Diabetes | O Liver Disease |
| O Asthma | O Drug Addiction | O Lung Disease/Emphysema |
| O Blood Pressure __ High __Low | O Fainting/Dizziness | O Psychiatric/Emotional Care |
| O Blood Transfusion | O Free-bleeding/Hemophilia/Blood Thinners | O Sickle Cell Disease |
| O Bone Disorders/Osteoporosis | O Heart Disease/Conditions | O Sinus Trouble (Chronic) |
| O Cancer/Chemotherapy/Radiation | O Heart Murmur/Mitral Valve Prolapse | O Thyroid/Endocrine Problems |
| O Cold Sores/Fever Blisters | O Hepatitis A | O Venereal Disease |

Any physical or special needs that we should be aware of? _____
Any other medical problems we should be aware of? _____
List any drugs or medications taken: _____
Is pre-medication required for dental treatment? O Yes O No

DENTAL INFORMATION:

Primary Dentist Name: _____ Date of Last Visit: _____
Habits: (please circle) Thumb/Finger Sucking to age: _____ Lip Sucking/Biting to age: _____

Have you had previous treatment for:
Orthodontics? O Yes O No If YES, please explain: _____
Periodontal Disease? O Yes O No If YES, please explain: _____
TMJ? O Yes O No If YES, please explain: _____

Have you ever had:

| | | |
|---|---|---|
| Speech problems? | O Yes | O No |
| Any injuries to face, head, mouth, or teeth? | O Yes | O No |
| Headaches, facial pain, or jaw joint problems? | O Yes | O No |
| Clicking or locking of jaws? | O Yes | O No |
| Bleeding gums? | O Yes | O No |
| Excessive fear or anxiety during dental treatment? | O Yes | O No |
| Tonsils/adenoids removed? | O Yes | O No |
| Any type of dental surgery (extractions, implants, jaw surgery)? | O Yes | O No |

If YES, please explain: _____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that it is my responsibility to inform the dental office of any changes in medical status.**

_____ _____

**PATIENT SIGNATURE (or parent of minor) completing form** **DATE**