Chambers Street **Orthodontics**
for Children and Adults

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Medical History (Page 1)

Patient's Name: _____ Date of Birth: _____

Name of General Dentist: _____ Today's Date: _____

Please answer all questions correctly.

1. Are you under the care of a physician at the present time? _____
2. Are you presently taking any medications? _____
3. Have you been told you have trouble with your heart? _____
4. Has a physician ever told you that you have high blood pressure? _____
5. Have you ever had rheumatic fever? _____
6. Have you had or do you now have AIDS, Hepatitis, or other infectious disease? _____
7. Do you have allergies? _____
8. Are you allergic to any drugs? _____
9. Do you have diabetes (sugar disease)? _____
10. Do you have any bleeding problems? Prolonged bleeding following tooth infections or cuts? _____
11. Have you had previous extractions with local anesthetic (shots) or general anesthesia (gas)? If so, please underline the appropriate word. _____
12. Have you had any trouble when you have had a tooth removed? Did you have prolonged bleeding, excess swelling, pain, infection, or other? If so, please underline the appropriate word. _____
13. Have you ever been treated with steroids, cortisone, or radiation (x-ray therapy)? _____
14. Have you ever had venereal disease (bad blood)? _____
15. Have you ever had any operations or major surgery, serious illness or been hospitalized for any length of time? _____
16. Are you pregnant? _____

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Medical History (Page 2)

17. Do you have a heart murmur? _____

18. Do you have any prosthetic joints or heart valves? _____

19. Have you ever had tuberculosis, asthma, or other lung troubles, yellow jaundice, liver trouble, gall bladder trouble, anemia, or epileptic convulsions, "fits," or seizures? _____

20. Are there any other problems with your health that you are aware of? _____

21. Has it been more than six months since your last visit to the dentist for a cleaning and exam? _____

22. Address and Phone Number of General Dentist: _____

_____

IMPORTANT: A change in your medical/dental status should be reported to the office as soon as possible!

To the best of my knowledge, all of these questions have been answered correctly.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF PARENT: _____ DATE: _____

Thank You!

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