

MEDICAL HISTORY

Please fill out everything to the best of your knowledge.

PATIENT NAME _____

Physician's Name _____ Phone# _____

Any history of major illness? Y or N If so, what? _____

Has the patient been hospitalized in the last 5 years? Y or N

If yes please explain why _____

Check any of the following for which patient has been treated and/or is currently being treated for:

Diabetes _____	Asthma _____	Kidney Involvement _____
Pneumonia _____	Anemia _____	Rheumatic Fever _____
Bone Disorders _____	Epilepsy _____	Endocrine Problems _____
Tuberculosis _____	Heart Problems _____	Prolonged Bleeding _____
Fainting or Dizziness _____	Nervous Disorders _____	Liver Involvement _____

Other _____ Please explain _____

Does patient have tendency to colds? Y or N sore throats? Y or N ear infections? Y or N

Have tonsils & adenoids been removed? Y or N

Does patient have a condition where he/she needs to be pre-medicated? Y or N

If so, for what reason? _____

List any current drugs and/or medications, give reasons for why each is being taken

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Any allergies or drug sensitivities? Y or N or Unaware

If yes, please explain _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, teeth? Y or N

Has patient ever sucked a thumb or fingers? Y or N if yes till what age? _____

Does patient have speech problems? Y or N

Is patient a mouth breather? Y or N if yes, Awake? Y or N Asleep? Y or N

Have you been informed of any missing or extra teeth? Y or N

List any musical instruments played _____

Has an orthodontist been consulted previously? Y or N