STEPHEN W. ANDREWS, D.M.D., M.S.
Specialist in Orthodontics

DATE _____

PATIENT'S NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ PATIENT'S DATE OF BIRTH _____

PATIENT'S DENTIST _____ LAST VISIT _____

REFERRED BY _____

PERSON(S) RESPONSIBLE FOR ACCOUNT _____

IF MINOR:

FATHER'S NAME _____ MARITAL STATUS _____

EMPLOYER _____

ADDRESS _____ PHONE _____

SOCIAL SECURITY NO. _____

MOTHER'S NAME _____MARITAL STATUS _____

EMPLOYER _____

ADDRESS _____ PHONE _____

SOCIAL SECURITY NO. _____

ADULT PATIENTS:

EMPLOYER _____ PHONE _____

SOCIAL SECURITY NO. _____

SPOUSE'S EMPLOYER _____ PHONE _____

WILL PATIENT BE COVERED BY INSURANCE? WHAT COMPANY? _____

ANY UNUSUAL ILLNESS? _____ ALLERGIES: _____

ANY PREVIOUS ORTHODONTIC TREATMENT? _____

BY DR. _____

REASON FOR VISIT? _____

DOES PATIENT:

1. SUCK THUMB, FINGERS, LIP OR PENCILS? _____
2. BREATHE THROUGH THE MOUTH? _____
3. HAVE WHITE OR BROWN SPOTS ON THE TEETH? _____
4. HAVE HEADACHES? _____
5. CLICKING OR POPPING NOISES IN THE JOINT WHEN CHEWING? _____
6. WAKE WITH THE JAWS FEELING TIRED? _____
7. PLAY A MUSICAL INSTRUMENT? _____

_____ _____

RESPONSIBLE PARTY (IF PATIENT IS A MINOR) PATIENT

THE INITIAL EXAMINATION IS FOR DISCUSSION OF THE TENTATIVE TREATMENT PLAN AND FEE.

Medical History Form

Date _____

Name _____ Home Phone (_____)_____
Last First Middle

Address _____ Business Phone (_____)_____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth _____/_____/_____ Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day year

Name of Spouse _____ Closest Relative _____ Phone (_____)_____

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

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

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
If so, what is the condition being treated? _____

5. The name and address of my physician(s) is _____
_____
_____

6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No
If so, what was the illness or problem? _____

7. Are you taking any medicine(s) including non-prescription medicine? . . . . . Yes No
If so, what medicine(s) are you taking? _____

8. Do you have or have you had any of the following diseases or problems?

- **a**. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease . . . . . Yes No
- **b**. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No
  - **1**. Do you have chest pain upon exertion ? . . . . . Yes No
  - **2**. Are you ever short of breath after mild exercise or when lying down? . . . . . Yes No
  - **3.** Do your ankles swell ? . . . . . Yes No
  - **4.** Do you have inborn heart defects? . . . . . Yes No
  - **5.** Do you have a cardiac pacemaker? . . . . . Yes No
- **c.** Allergy . . . . . Yes No
- **d.** Sinus trouble . . . . . Yes No
- **e.** Asthma or hay fever . . . . . Yes No
- **f.** fainting spells or seizures . . . . . Yes No
- **g.** Persistent diarrhea or recent weight loss . . . . . Yes No
- **h.** Diabetes . . . . . Yes No
- **i.** Hepatitis, jaundice or liver disease . . . . . Yes No
- **j.** AIDS or HIV infection . . . . . Yes No
- **k.** Thyroid problems . . . . . Yes No
- **l.** Respiratory problems, emphysema, bronchitis, etc. . . . . Yes No
- **m.** Arthritis or painful swollen joints . . . . . Yes No
- **n.** Stomach ulcer or hyperacidity . . . . . Yes No
- **o.** Kidney trouble . . . . . Yes No
- **p.** Tuberculosis . . . . . Yes No
- **q.** Persistent cough or cough that produces blood . . . . . Yes No
- **r.** Persistent swollen glands in neck . . . . . Yes No
- **s.** Low blood pressure . . . . . Yes No
- **t.** Sexually transmitted disease . . . . . Yes No
- **u.** Epilepsy or other neurological disease . . . . . Yes No
- **v.** Problems with mental health . . . . . Yes No
- **w.** Cancer . . . . . Yes No
- **x.** Problems of the immune system . . . . . Yes No

9. Have you had abnormal bleeding? . . . . . Yes No
a. Have you ever required a blood transfusion? . . . . . Yes No

10. Do you have any blood disorder such as anemia? . . . . . Yes No

11. Have you ever had any treatment for a tumor or growth? . . . . . Yes No

12. Are you allergie or have you had a reaction 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. Other _____

13. Have you had any serious trouble associated with any previous dental treatment ? . . . . . Yes No
If so, explain _____

14. Do you have any disease, condition, or problem not listed above that you think I should know about ? . . . . . Yes No
If so, explain _____

15. Are you wearing contact lenses? . . . . . Yes No

16. Are you wearing removable dental appliances? . . . . . Yes No

Women
17. Are you pregnant? . . . . . Yes No

18. Do you have any problems associated with your menstrual cycle? . . . . . Yes No

19. Are you nursing? . . . . . Yes No

20. Are you taking birth control pills? . . . . . Yes No

Chief Dental Complaint _____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by the orthodontist.
Comments on patient interview concerning medical history: _____
_____
_____
Significant findings from questionnaire or oral interview: _____
_____
_____
Dental management considerations: _____
_____
_____

_____ _____
Date Signature of Orthodontist

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____