

MEDICAL HISTORY

Adult

Physician's Name _____	Address _____	Phone _____
Are you currently experiencing health problems?	No Yes	Explain: _____
Are you currently taking any medications?	No Yes	List: _____
Are you allergic to any medications?	No Yes	List: _____
Have your tonsils or adenoids been removed?	No Yes	When: _____
Please check if you have the following conditions:		
Heart murmur <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Emotional Disorder <input type="checkbox"/>
Heart surgery <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>
Kidney disease <input type="checkbox"/>	HIV positive <input type="checkbox"/>	Endocrine disorder <input type="checkbox"/>
Liver disease <input type="checkbox"/>	Cancer <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Bone disorders <input type="checkbox"/>	Growth disorder <input type="checkbox"/>	Blood disease <input type="checkbox"/>
Asthma <input type="checkbox"/>	Mouth Breathing <input type="checkbox"/>	Developmental Disorder <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Allergies <input type="checkbox"/>	Hepatitis <input type="checkbox"/>

DENTAL HISTORY

Is there any unfinished dental care?	No Yes	
Are you apprehensive about dental treatment?	No Yes	
Have you had previous orthodontic treatment?	No Yes	
(With Whom:) _____		
Please check if there is a history of :		
Clenching <input type="checkbox"/>	Muscular soreness around head & neck <input type="checkbox"/>	Jaw joint soreness <input type="checkbox"/>
Grinding Teeth <input type="checkbox"/>	Headaches <input type="checkbox"/>	Jaw joint popping/clicking <input type="checkbox"/>
Ringling in the ears <input type="checkbox"/>	Speech problems <input type="checkbox"/>	Other <input type="checkbox"/>
Is there any more information that may be helpful? _____		

I understand that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence per HIPPA regulations. It is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform the necessary dental services. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. Signature: _____

Health History Review: _____
