

**Patient Medical History**  
**(Confidential)**

**Name** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**Date** \_\_\_\_\_

It is important for our office to be aware of any information concerning your past medical history.

1. Have you been under the care of a medical doctor during the past three years (for anything other than routine/wellness visits)?  
Yes\_\_\_ No\_\_\_

Brief explanation:

2. Have you been a patient in the hospital during the past three years?  
Yes\_\_\_ No\_\_\_

3. Have you taken any medication during the past two years?  
Yes\_\_\_ No\_\_\_

4. Any allergies or problems/allergies to medications?  
Yes\_\_\_ No\_\_\_  
If yes, please list:

5. Have you ever had hepatitis? Yes\_\_\_  
No\_\_\_

6. Have you had any serious problems with infections or bleeding, blood disorders or immune disorder? Yes\_\_\_  
No\_\_\_

7. Have you ever been told you have a heart murmur or have you had rheumatic fever? Yes\_\_\_  
No\_\_\_

8. Have you ever been diagnosed with any bone diseases such as osteopenia, Osteoporosis or Pagets disease?  
Yes\_\_\_ No\_\_\_

-Are you currently being treated for any of these diseases?  
Yes\_\_\_ No\_\_\_

-Are you taking any medications? (Please list)  
Yes\_\_\_ No\_\_\_

-Have you ever been treated for these diseases?

Yes\_\_\_ No\_\_\_

If yes, when?

-Have you ever taken a bone building or strengthening medication to reduce bone loss, such as Fosamax?

Yes\_\_\_

No\_\_\_

**Please turn form over to complete** →

9. Have you ever been diagnosed or treated for hypercalcemia or cancer due to malignancy? Yes\_\_\_

Yes\_\_\_

No\_\_\_

-Are you currently being treated for any of these diseases?

Yes\_\_\_ No\_\_\_

-Are you taking any medications? (Please list)

Yes\_\_\_ No\_\_\_

-Have you ever been treated for these diseases? If yes, when?

Yes\_\_\_ No\_\_\_

11. Do you experience any of the following problems?

Jaw clicking \_\_\_ Pain (joint, ear, side of face) \_\_\_  
Difficulty chewing \_\_\_ Difficulty in opening or closing \_\_\_  
Frequent headaches \_\_\_ Clench or grind your teeth \_\_\_

12. For women only: Is there any chance you may be pregnant?

Yes\_\_\_ No\_\_\_

13. Have you had prior orthodontic treatment? Yes\_\_\_

Yes\_\_\_

No\_\_\_

If yes, Where \_\_\_\_\_

When \_\_\_\_\_

**Name of physician** \_\_\_\_\_

**Address** \_\_\_\_\_

Responsible party signature \_\_\_\_\_

Information taken by \_\_\_\_\_