Orthodontic Health Data Sheet

Patient Name_____Date_____Chart#_____

Are you in poor health? YES NO

Are you under the care of a physician? YES NO

If yes, why? _____

Have you had any serious illness or operation? YES NO

If yes, what?_____

Do you have or have you had any of the following diseases or problems:

Damaged or artificial heart valves YES NO

Congenital heart lesions or murmers YES NO

Cardiovascular disease (heart trouble) YES NO

Are you short of breath after mild exercise? YES NO

Do you have a cardiac pacemaker? YES NO

Have you ever had rheumatic fever? YES NO

Sinus trouble YES NO

Asthma YES NO

Allergy YES NO

Hives or skin rash YES NO

Fainting spells or seizures YES NO

Diabetes YES NO

Hepatitis, jaundice or liver disease YES NO

HIV/AIDS YES NO

Arthritis/rheumatism/painful joints YES NO

Stomach ulcers YES NO

Kidney trouble YES NO

Tuberculosis YES NO

Persistant cough, or cough up blood YES NO

Low blood pressure YES NO

Venereal Disease YES NO

Do you have a prosthetic hip___ joint prosthesis___ implants___ bone plates___ bone screws___ other_____ YES NO

Have you had abnormal bleeding associated with previous extraction, surgery or trauma? YES NO

Do you bruise easily? YES NO

Have you had a blood transfusion YES NO

If yes, why?_____

Have you ever taken Redux or Fen-Phen? YES NO

Are you pregnant? YES NO

Do you have anemia or other blood disorder? YES NO

Are you taking any of the following medicines:

Antibiotics/sulfa	YES	NO	Blood Thinners	YES	NO
Blood pressure	YES	NO	Thyroid	YES	NO
Cortizone/steroids	YES	NO	Tranquilizers	YES	NO
Insulin/diabetes	YES	NO	Aspirin/pain	YES	NO
Digitalis/heart	YES	NO	Nitroglycerin	YES	NO
Antihistamine/Allergy	YES	NO	Cold/flu	YES	NO

If yes to any of the above, please list name and dosage:

_____

_____

_____

Are you allergic or have you had a reaction to:

Local anesthetics YES NO

Barbiturates/sedatives/sleeping pills YES NO

Antibiotics/penicillin/sulfa YES NO

Aspirin/codeine YES NO

Latex or rubber products YES NO

Nickel or other metals YES NO

Other allergies_____

Do you have any other disease, condition or problem that you think I should know about? YES NO

If yes, what?_____

Do you have any of the following:

Bleeding/sore gums	YES	NO	Biting cheeks	YES	NO
Popping/pain in jaw	YES	NO	Jaw locks open	YES	NO
Loose/sensitive teeth	YES	NO	Blisters/sores	YES	NO
Shifting of teeth	YES	NO	Change in bite	YES	NO

Your medical doctor is:

Name_____Phone_____

Address_____

By signing I certify that I have read and filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware.
I further consent to necessary x-rays and orthodontic exam for myself or the above named minor, of whom I am parent or legal guardian.

_____

Patient/parent/guardian Date

_____

Dentist Date

_____

_____

_____

_____