

Smile Elements Orthodontics | Health History

Name: _____ Today's Date (DD/MM/YY): _____ / _____ / _____

CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question)

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam? _____
Name of Physician and his/her telephone number: _____
5. Yes No Are you in pain now? _____

HAVE YOU EXPERIENCED THE FOLLOWING?

- | | |
|--|-----------------------------------|
| 6. Yes No Chest Pain (angina)? | 17. Yes No Dizziness? |
| 7. Yes No Swollen ankles? | 18. Yes No Ringing in the ears |
| 8. Yes No Shortness of breath? | 19. Yes No Headaches? |
| 9. Yes No Recent weight loss, fever, night sweats? | 20. Yes No Fainting spells? |
| 10. Yes No Persistent cough, coughing up blood? | 21. Yes No Blurred vision? |
| 11. Yes No Bleeding problems, bruising easily? | 22. Yes No Seizures? |
| 12. Yes No Sinus problems? | 23. Yes No Excessive thirst? |
| 13. Yes No Difficulty swallowing? | 24. Yes No Frequent urination? |
| 14. Yes No Diarrhea, constipation, blood in stool? | 25. Yes No Dry mouth? |
| 15. Yes No Frequent vomiting, nausea? | 26. Yes No Jaundice? |
| 16. Yes No Difficulty urinating? | 27. Yes No Joint pain, stiffness? |

DO YOU HAVE OR HAVE YOU HAD?

- | | |
|--|--|
| 28. Yes No Heart disease? | 39. Yes No AIDS or HIV? |
| 29. Yes No Heart attack, heart defects? | 40. Yes No Tumors, cancer? _____ |
| 30. Yes No Heart murmurs? | 41. Yes No Arthritis, rheumatism? |
| 31. Yes No Rheumatic fever? | 42. Yes No Eye diseases? |
| 32. Yes No Stroke, hardening of arteries? | 43. Yes No Skin diseases? |
| 33. Yes No High blood pressure? | 44. Yes No Anemia? |
| 34. Yes No TB, emphysema, other lung diseases? | 45. Yes No STD (sexually transmitted disease)? |
| 35. Yes No Hepatitis? | 46. Yes No Herpes? (cold sores)? |
| 36. Yes No Stomach problems, ulcers? | 47. Yes No Kidney, bladder disease? |
| 37. Yes No Allergies to: drugs, foods, medications? Which ones? _____ | 48. Yes No Thyroid, adrenal disease? |
| 38. Yes No Family history of diabetes, heart problems, tumors? | 49. Yes No Diabetes? |

DO YOU HAVE OR HAVE YOU HAD:

- | | |
|------------------------------------|--------------------------------|
| 50. Yes No Psychiatric care? | 55. Yes No Hospitalization? |
| 51. Yes No Radiation treatments? | 56. Yes No Blood transfusions? |
| 52. Yes No Chemotherapy? | 57. Yes No Surgeries? _____ |
| 53. Yes No Prosthetic heart valve? | 58. Yes No Pacemaker? |
| 54. Yes No Artificial joint? | 59. Yes No Contact lenses? |

ARE YOU TAKING:

- | | |
|---|---------------------------------|
| 60. Yes No Recreational drugs? | 62. Yes No Tobacco in any form? |
| 61. Yes No Drugs, medicine (including Aspirin)? Please list: _____ | 63. Yes No Alcohol? |

FOR WOMEN ONLY:

- | | |
|---|--|
| 64. Yes No Are you or could you be pregnant or nursing? | 65. Yes No Taking birth control pills? |
|---|--|

FOR ALL PATIENTS:

66. Yes No Do you have or have you had any other diseases or medical conditions/problems NOT listed on this form? If so, please explain: _____

To the best of knowledge, I have answered every question completely and accurately. I will inform my dentist/hygienist of any change in my health and/or medication(s).

Patient's (if patient is a minor, parent/guardian) signature: _____ Date: _____

I understand that I am responsible for fees associated with treatment performed including those not covered by my dental insurance plan, if any. I further understand that payment is due on the day of service unless other arrangements have been made prior to the treatment being performed.

Patient's (if patient is a minor, parent/guardian) signature: _____ Date: _____