PARTRICK ORTHODONTICS **Health History**

Instructions: *Please Read and review all questions. Answer all questions by circling yes, no, or unsure. All questions should be answered truthfully. Incorrect or omitted information may be dangerous to your health. Please explain any yes or unsure answers on the line provided.*

Patient's name_____

Date of birth _____ **Today's Date** _____

Please list medication names and dosages: _____

_____

Name and phone number of physician(s):_____

Name and phone number of dentist:_____

Do you take any type of antibiotic?	Unsure	No	Yes: _____
Do you take insulin?	Unsure	No	Yes: _____
Do you take any type of heart medication?	Unsure	No	Yes: _____
Do you take a diuretic?	Unsure	No	Yes: _____
Do you take any type of blood thinner?	Unsure	No	Yes: _____
Do you take any antidepressants?	Unsure	No	Yes: _____
Do you take any tranquilizers?	Unsure	No	Yes: _____
Do you take aspirin, Tylenol or any pain medications?	Unsure	No	Yes: _____
Do you take birth control pills?	Unsure	No	Yes: _____
Do you take hormones, cortisone or steroids?	Unsure	No	Yes: _____
Do you use an inhaler?	Unsure	No	Yes: _____
Do you take any cancer drugs?	Unsure	No	Yes: _____
Do you take any other medications?	Unsure	No	Yes: _____
Are you allergic to Novocain?	Unsure	No	Yes: _____
Are you allergic to Iodine?	Unsure	No	Yes: _____
Are you allergic to Penicillin?	Unsure	No	Yes: _____
Are you allergic to sulfa drugs?	Unsure	No	Yes: _____
Are you allergic to any other antibiotics?	Unsure	No	Yes: _____
Are you allergic to codeine?	Unsure	No	Yes: _____
Are you allergic to aspirin/Tylenol?	Unsure	No	Yes: _____
Are you allergic to Barbiturates?	Unsure	No	Yes: _____
Are you allergic to any narcotics?	Unsure	No	Yes: _____
Do you have any other allergies?	Unsure	No	Yes: _____
Have you ever had Rheumatic heart Disease?	Unsure	No	Yes: _____
Have you ever had a congenital heart disease?	Unsure	No	Yes: _____
Have you ever had a heart murmur?	Unsure	No	Yes: _____
Have you ever had a heart attack? When?	Unsure	No	Yes: _____
Have you ever had angina? Last episode date?	Unsure	No	Yes: _____
Have you ever had heart surgery? When?	Unsure	No	Yes: _____
Do you have a pacemaker?	Unsure	No	Yes: _____
Have you ever had an irregular heartbeat?	Unsure	No	Yes: _____
Do you have a prosthetic heart valve? Surgery date?	Unsure	No	Yes: _____
Have you ever had excessive bleeding?	Unsure	No	Yes: _____
Do you have Hemophilia?	Unsure	No	Yes: _____
Have you ever had anemia?	Unsure	No	Yes: _____
Have you ever had low or high blood pressure?	Unsure	No	Yes: _____
Have you ever had Asthma?	Unsure	No	Yes: _____
Do you have breathing problems?	Unsure	No	Yes: _____
Do you have a persistent cough?	Unsure	No	Yes: _____
Have you ever had Tuberculosis?	Unsure	No	Yes: _____
Have you ever undergone radiation treatment?	Unsure	No	Yes: _____
Have you ever had chemotherapy?	Unsure	No	Yes: _____
Have you ever had cancer?	Unsure	No	Yes: _____
Have you ever had tumors or growths?	Unsure	No	Yes: _____
Do you have Diabetes?	Unsure	No	Yes: _____
Have you ever had a joint surgery?	Unsure	No	Yes: _____

Do you have any internal plates or rods? Unsure No Yes: _____
Do you have any implants or prosthesis? Unsure No Yes: _____
Do you wear a back brace? Unsure No Yes: _____
Have you ever had Hepatitis? Unsure No Yes: _____
Have you ever had liver disease? Unsure No Yes: _____
Have you ever had any kidney problems or dialysis? Unsure No Yes: _____
Have you ever had a psychiatric disorder? Unsure No Yes: _____
Have you ever been treated by a psychiatrist or counselor? Unsure No Yes: _____
Have you ever had depression or fatigue syndrome? Unsure No Yes: _____
Have you ever suffered a stroke? Unsure No Yes: _____
Have you ever had a seizure/Epilepsy? Unsure No Yes: _____
Have you ever suffered fainting spells? Unsure No Yes: _____
Do you have Arthritis? Unsure No Yes: _____
Have you been diagnosed with AIDS/HIV? Unsure No Yes: _____
Have you ever had syphilis, herpes or gonorrhea? Unsure No Yes: _____
Have you ever had a serious head or neck injury? Unsure No Yes: _____
Have you ever had a major operation? Unsure No Yes: _____
Are you on a special diet? Unsure No Yes: _____
Do you use smokeless tobacco products? Unsure No Yes: _____
Have you ever used recreational drugs? Unsure No Yes: _____
(*For women*) Are you pregnant? Unsure No Yes: _____
(*For women*) Are you breastfeeding? Unsure No Yes: _____
Do you have any medical condition we should be aware of? Unsure No Yes: _____
Do you have any mental or additional physical disabilities not addressed above? No Yes: _____
How much alcohol do you drink a week? _____
How many packs of cigarettes do you smoke a day? _____
(For kids/teens) Have you had a recent growth spurt where your shoes are too small or your pants are too short? Unsure No Yes
(For girls) What is the date of your first menstrual period? _____ Have not had a menstrual period yet☐

Dental History

What dental problem brought you in today?_____
Do you have any dental concerns or complaints?_____
Are you worried about receiving dental care? Unsure No Yes: _____
Have you ever had any problems after a dental treatment? Unsure No Yes: _____
Are you **UNHAPPY** with the appearance of you teeth? Unsure No Yes: _____
Have you ever had an injury to your teeth, jaw or face? Unsure No Yes: _____
Do you grind or clench your teeth? Which one? Unsure No Yes: _____
Do any of your teeth hurt? Unsure No Yes: _____
Are your teeth sensitive to hot or cold? Unsure No Yes: _____
Are any of you teeth becoming loose? Unsure No Yes: _____
Any growths or sores in your mouth? Unsure No Yes: _____
Have your teeth shifted? Unsure No Yes: _____
Do you gums bleed? Unsure No Yes: _____
Have you ever sucked your thumb? Until what age? Unsure No Yes: _____
Do you have any speech problems? If so, explain. Unsure No Yes: _____
Have you ever had braces or orthodontics before? Unsure No Yes: _____
Do you ever have problems with your jaw joints (TMJ)? Explain. No Yes: _____
Date of last dental visit to dentist? Unsure _____
Reason for last dental visit? Unsure _____
How often do you brush your teeth a day? _____
How often do you floss a day?_____

I understand the need for these questions to be answered truthfully and to the best of my knowledge. The answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time and I agree to do so. I give my permission to the dentist to obtain from my personal physical any additional information regarding my medical history needed to provide me the best dental care treatment possible.

Person completing this form (signature) _____ Date _____
If other than patient, relationship _____ (*Office Use Only*) Reviewed by _____