PATIENT MEDICAL HISTORY

For the following questions please mark YES or NO.
Your answers are for our records only and are considered confidential.
Please let us know if there are any changes in the future.

Patient Name: ________________________ **Date of Birth:** ____________ **Today's Date**: ____________

MEDICAL INFORMATION

Primary Medical Doctor: ______________________ Office Location: ______________________

Phone #: ______________ Kaiser # ______________ Date of last visit: ______________________

NOW OR IN THE PAST, HAS PATIENT HAD:

yes no Allergies to medications? Ibuprofen, Acetaminophen?
Other?______________________

yes no Allergies to latex, metal, other: ______________

yes no Prosthetic joint or other replacement? When? __________
Which Joint? ______________

yes no Has a physician recommended that patient take antibiotics prior to his/her dental treatment?

yes no Use tobacco (chew, smoke, snuff)? packs/day? ________

yes no Taking any prescription or non-prescription medication, nutritional supplements, or herbal medicines?

Medication: ______________ Taken For: ______________

Medication: ______________ Taken For: ______________

Medication: ______________ Taken For: ______________

yes no History of Major illness? ______________________

____

____

yes no Operations or Accidents? ______________________
When?______________________

yes no Osteoporosis? Bone density issues? Taking medications for bone density or may have to in the future?
What drug?______________________
When started? ______________________

Circle:

Arthritis	Anemia	Asthma/Hay fever
Bone Disorders	Diabetes	Dizziness/Fainting
Aids/HIV Positive	Hepatitis	Herpes
Nervous Disorders	Pneumonia	Prolonged
High Blood Pressure	Kidney Disorder	Liver Disorder
Rheumatic Fever	Tuberculosis	Tumor/Cancer
Heart Problems	Heart Murmur	Epilepsy
Gastrointestinal		

yes no Any other conditions you feel we should know about?
____

WOMEN ONLY:

yes no Has menstruation begun? When? ______________

yes no Pregnant now?

DENTAL INFORMATION

What would you like to change about your smile?
____
____

Circle: Would you like to wear braces? or Invisalign?

yes no Do you floss? __________ Times per day? __________

yes no Do you brush your teeth? ______ Times per day? ________

yes no Bleeding gums, bad taste or mouth odor?

yes no Difficulty in chewing or jaw clenching, clicking, or locking?

yes no Tooth grinding or clenching?

yes no Injuries to face, mouth, teeth or chin? **(circle)**

yes no Do you gag easily?

yes no Are your teeth sensitive?

yes no Have you had problems with previous dental treatments?

yes no Are you apprehensive about dental treatment?

yes no Play a musical instrument? ______________________

yes no Play a sport? ______________________

Signature Parent/Patient:______________________ Date: ______________

Signature Orthodontist: ______________________ Date: ______________

UPDATES OR CHANGES

Date	Comments/Updated	Signature	Staff Initial

"Your Smile is Our Specialty"

Constance M. Brown, DDS * 300 SE 120th Avenue * 3600 Main Street * 360-256-7220
www.brownorthodontics.com