


BE Orthodontics
Bailey-Bruster & Ellis Orthodontics



Medical and Dental History

Patient's Name _____

Physician's Name _____ Phone Number _____

Please answer the following questions:

1. Is the patient under the care of a physician? Yes No
If yes, why? _____
2. Is the patient taking any medications? Yes No
If yes, what? _____
3. Has patient been hospitalized in the past 2 years? Yes No
4. **(WOMEN)** To your knowledge are you pregnant? Yes No
5. Check the conditions that the patient has ever had a problem with:

- | | | |
|---|---|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Cancer/Radiation Therapy |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Kidney disorder |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> HIV | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Herpes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High or low Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Speech or Hearing |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> TB or Lung Disease | <input type="checkbox"/> Joint Replacements |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Ulcers | |

The patient has had no history of ANY of the medical problems listed above.

6. The patient has had an allergic reaction to:
 Penicillin Erythromycin Tetracycline Novocaine Codeine
 Aspirin Metals Latex Gloves Other _____

The patient has never had an allergic reaction to any drugs, medications or materials.

I UNDERSTAND THE IMPORTANCE OF NOTIFYING MY ORTHODONTIST(S) OF ANY MEDICAL CHANGES UPON EACH VISIT.

Signature _____ Date _____

Orthodontist _____ Date _____