Hollywood Orthodontics
3113 Stirling Road Suite # 101
Fort Lauderdale, FL 33312
954-981-5333

ORTHODONTIC MEDICAL HISTORY

Today's Date:_____ Referred by:_____

Patient's Name:_____ DOB: _____ Age:_____ Sex:_____

Parent/legal guardian name if patient is a minor:_____

Address:_____ Apt #_____

City/State:_____ Zip Code:_____

Cellular phone # ( ) _____ Email:_____

School Name: _____ Grade: _____

General Dentist Name:_____ Phone# _____

History of previous medical conditions: If you have a certain condition or are taking certain medications, it might be necessary to later your treatment; this is why we should know the following health information.

Have you had or do you have?

	YES	NO
1. Asthma, sinus problems or allergies?		
2. Allergic to penicillin, local anesthesia or other medications?		
3. High blood pressure or heart problems?		
4. Rheumatic fever or heart murmur?		
5. Do you have a pacemaker or have you had heart surgery?		
6. Ulcers or problems associated with: diabetes, liver, thyroids or lungs?		
7. Ulcers or stomach problems?		
8. Hepatitis or ictericia?		
9. Epilepsy or nervous problems?		
10. Abnormal bleeding?		
11. Arthritis?		
12. Venereal diseases, herpes?		
13. HIV or AIDS?		
14. Any other illness?		
15. Are you currently taking any medications? Please specify		
16. Are you currently under the care of a doctor?		
17. Do you have pain around your jaw or ear?		
18. Do you have cold sores or herpes in your mouth?		
19. Have you had chemotherapy or radiation treatment?		
20. Do you grind your teeth?		
21. Women: Are you pregnant?		

22. Do you have any other medical condition not mentioned above that you think we need to know of?

_____ _____
Signature of Patient/Parent or guardian if patient is a minor Date:

Printed Name: _____