



ORTHODONTICS
in the highlands

3538 West 44th Ave. • Denver CO 80211 • p: 303.433.7500 • f: 303.433.7501 • w: www.orthointhehighlands.com

PATIENT MEDICAL HISTORY

DATE: _____

Patient Name: _____
Last First MI (Nickname)

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | Months Pregnant _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies (List Below) | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors |
| _____ | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers |
| _____ | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |

Girls only: Date of first menstruation _____

Have you ever had any complication following dental treatment? Yes No
 If yes, please explain: _____

Have you been admitted to a hospital during the past two years? Yes No
 If yes, please explain: _____

Are you now under the care of a physician? Yes No
 If yes, please explain: _____

Name of Physician: _____ Phone Number: _____

Do you have any health problems that need further clarification? Yes No
 If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform your office at the next appointment without fail.

Signature of patient, parent or guardian: _____ **Date:** _____