

Medical Health History

Patient's Name (Last / First): _____ Date: _____

Y ___ N ___ Are you in general good health? Date of your last medical exam: _____

Y ___ N ___ Has there been any change in your general health within the last year?

Y ___ N ___ Is a physician treating you for a specific illness? IF YES, what? _____

Y ___ N ___ Have you been hospitalized / seriously ill in the past 5 years? _____

Female Patients Only:

Y ___ N ___ Are you or could you be pregnant? When are you due? _____

Y ___ N ___ Do you anticipate becoming pregnant? Y ___ N ___ Are you taking birth control pills?

Y ___ N ___ Are you nursing?

HAVE YOU RECEIVED ANY OF THE FOLLOWING?

Y ___ N ___ Psychiatric care

Y ___ N ___ Radiation Treatment, Chemotherapy

Y ___ N ___ Prosthetic /Artificial heart valve

Y ___ N ___ Artificial hip or joint

Y ___ N ___ Blood transfusion

Y ___ N ___ Pacemaker

HAVE YOU USED ANY OF THESE SUBSTANCES?

Y ___ N ___ Fosamax, Actonel, Aredia, Zometa (Bisphosphates)

Y ___ N ___ Phen-fen (Weight loss medicine)

Y ___ N ___ Tobacco in any form

Y ___ N ___ Recreational drugs

Y ___ N ___ Corticosteroids

Y ___ N ___ Alcohol

List ALL CURRENT MEDICATIONS and the CORRELATING DIAGNOSIS on the line below:

(_____)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES/CONDITIONS:

Y ___ N ___ Heart attack, Heart disease, Congestive heart failure Y ___ N ___ Thyroid, adrenal disease Y ___ N ___ Rheumatic fever

Y ___ N ___ Heart murmur, Mitral valve prolapse, Heart defect Y ___ N ___ Anemia, Other blood disorder Y ___ N ___ HIV/AIDS or Exposure

Y ___ N ___ Scarlet Fever Y ___ N ___ Epilepsy Y ___ N ___ Ulcers, other stomach problems

Y ___ N ___ TB, Asthma, emphysema, other lung disease Y ___ N ___ Arthritis, Rheumatism Y ___ N ___ Stroke

Y ___ N ___ Hepatitis, Jaundice, other liver disease Y ___ N ___ Skin Disease Y ___ N ___ Kidney disease, Bladder disease

Y ___ N ___ Herpes, HPV, Syphilis, Gonorrhea Y ___ N ___ Anorexia, Bulimia Y ___ N ___ Diabetes, Hyperglycemia

Y ___ N ___ High Blood Pressure, Atherosclerosis Y ___ N ___ Glaucoma, other eye disease Y ___ N ___ Fainting

Y ___ N ___ Family history of diabetes, heart problems or tumors. If yes, please explain : _____

Y ___ N ___ Allergies to: Antibiotics, Medicines, Latex, Food, OTHER ALLERGIES _____

Y ___ N ___ Do you have any disease, condition or problem not listed on this form? If yes, please explain: _____

To the best of my knowledge, I have answered all questions completely & accurately. I understand that it is my responsibility to inform my dental practitioner if I, or my minor child, ever have a change in health/ medications. I give you permission to contact my physician for further details and advice.

Patient/Parent/Guardian Signature: _____ Date: _____ Orthodontist Signature _____ Date: _____

Yearly Signature Update: _____ Date: _____ Dr. Signature Update: _____ Date: _____

Yearly Signature Update: _____ Date: _____ Dr. Signature Update: _____ Date: _____

Dr. Andrew Chen – Specialist in Orthodontics

29955 Technology Drive #C112, Murrieta, CA, 92563
(951) 445-4223