



# Medical History Form

WELCOME TO BREWKA ORTHODONTICS!

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: **Male or Female** Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Who to call in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Please answer the following questions. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- 1. Are you in good health? Yes No
- 2. Has there been any change in your general health in the last year? Yes No
- 3. Are you now under the care of a Physician? Yes No  
If so, what is the condition being treated? \_\_\_\_\_
- 4. Date of your last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 5. Name & phone number of your Physician: \_\_\_\_\_
- 6. Have you had a serious illness, operation, or been hospitalized in the past 5 years? Yes No  
If so, what is the illness or condition? \_\_\_\_\_
- 7. Are you taking any medication including non-prescription? Yes No
- 8. Do you have any of the following:
  - Damaged/artificial heart valves, including heart murmur or Rheumatic heart disease Yes No
  - Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, stroke, or arteriosclerosis) Yes No
  - Do you have chest pain upon exertion Yes No
  - Are you ever short of breath after mild exercise or when lying down Yes No
  - Do your ankles swell Yes No
  - Do you have inborn heart defects Yes No
  - Do you have cardiac pacemaker Yes No
  - Allergy/Sinus trouble Yes No
  - Asthma or hay-fever Yes No
  - Fainting spells, seizures or other neurological disease Yes No
  - Persistent diarrhea or recent weight loss Yes No
  - Diabetes Yes No
  - Hepatitis, jaundice or liver disease Yes No
  - AIDS or HIV infection or other immune system conditions Yes No
  - Thyroid problems Yes No
  - Respiratory problems, emphysema bronchitis etc... Yes No
  - Arthritis or painful swollen joints Yes No
  - Stomach ulcer or hyperacidity Yes No
  - Kidney trouble Yes No
  - Tuberculosis Yes No
  - Persistent cough or cough that produces blood Yes No