HEALTH HISTORY

Orthodontic Associates of New England

Patient's Name: _____ Date of Birth: _____

Patient's Physician/Pediatrician: _____
Address: _____

Are you currently under a physician's care for any reason other than routine check ups?	Yes ____	No ____
Are you taking any pills, drugs or medications?	Yes ____	No ____
Do you have any heart problems or heart murmurs?	Yes ____	No ____
Do you have any implanted pins or plates from fractures or joint replacements which require premedication prior to dental treatment?	Yes ____	No ____
Do you need to take premedication prior to dental treatment?	Yes ____	No ____

Please explain any yes answers:

_____
_____
_____
_____

Women: Are you pregnant or is there a possibility you are pregnant? Yes ____ No ____

Are you allergic to any of the following?	Latex	Yes ____	No ____
	Acrylic	Yes ____	No ____
	Metal	Yes ____	No ____
	Local Anesthetics	Yes ____	No ____
	Other _____		

Please check if you have ever had any of the following:

____ AIDS/HIV Positive	____ Clotting Problems	____ Jaundice
____ Allergies	____ Diabetes	____ Kidney Problems
____ Angina	____ Epilepsy	____ Liver Disease
____ Arthritis	____ Fainting Spells	____ Neck Injury
____ Artificial Joint	____ Hemophelia	____ Seizures
____ Asthma	____ Hepatitis A	____ Transfusions
____ Blood Disorders	____ Hepatitis B or C	____ Tuberculosis

Have you ever had any illness, medical condition or hospitalizations not listed above? Yes ____ No ____
If yes, please explain _____
_____
_____

Are there any precautions we need to take prior to dental treatment? _____
_____
_____
_____

I have read and understand the above questions. I will not hold the Doctors and/or Staff of Orthodontic Associates of New England responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this medical history, I will inform the Doctors immediately.

_____ _____ _____
Signature-Patient (Parent/Guardian if under 18) | Relationship to Patient | Date

_____ _____
Reviewed by: | Date