Align Orthodontics

MEDICAL HISTORY

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

- ☐ High Blood Pressure
- ☐ Heart Ailment
- ☐ Rheumatic Fever
- ☐ Asthma, Chest or Breathing problems
- ☐ Tuberculosis
- ☐ Stomach or Bowel Problems (Ulcer)
- ☐ Kidney Disease
- ☐ Behavioral disorders
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Excessive bleeding or blood disorder
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ AIDS / HIV
- ☐ Bone Disorders or Diseases

Do you smoke? ☐ Yes ☐ No If yes how many a day? _____ Would you like to stop? ☐ Yes ☐ No

Please list any other previous illnesses _____

Do you have: an artificial hip, heart valve, or other prosthetic implant? _____

Have you ever had any problems with dental treatment? _____

Are you currently under any medical care? _____

Are you taking any drugs or prescribed medicines or tablets? _____

Female patients, are you pregnant? _____

Do you have any allergies? _____

Please list any medicines or products you are allergic to (e.g. Penicillin, Latex) _____

Would you like to discuss any of these questions in private with the orthodontist? _____

THANK YOU FOR YOUR ASSISTANCE IN COMPLETING THIS FORM AS ACCURATELY AS POSSIBLE.

I have completed this questionnaire to the best of my knowledge, and understand that failure to make a full disclosure may place me at undue medical risk. I understand that notes, radiographs (X-Rays), or models relating to my treatment may need to be sent to other dental practitioners to aid them in my treatment and consent to this. I also give my permission for the practice to use the above contact details to send me appointment and check up reminders:

Print name _____ Relationship _____

Signed _____ Date _____

(If under the age of 18 parent/guardian must sign)

PLEASE NOTE:
On future visits any changes to the above should be advised.

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