

GARTNER ORTHODONTICS, LTD. ADULT MEDICAL HISTORY

Patient's Name _____
 Physician's Name & Address _____

(CIRCLE THE APPROPRIATE ANSWERS)

1.	Have you ever had a serious illness or operation? If so, explain _____	Yes	No
2.	Are you under a physician's care?	Yes	No
3.	When was your last physical exam? _____		
4.	Are you taking any medication? If so, explain _____	Yes	No
5.	Do you have any allergies? Do you have any problems/allergies to penicillin, antibiotics, or other medications? If so, explain _____	Yes	No
6.	Have you been treated for, or been told you might have heart disease? Do you have a pacemaker or an artificial heart valve implant?	Yes	No
7.	Are you aware of any heart murmurs?	Yes	No
8.	Have you ever had rheumatic fever?	Yes	No
9.	Have you ever had surgery, radiation treatment, chemo treatment for a tumor, growth or other condition?	Yes	No
10.	Do you have high or low blood pressure?	Yes	No
11.	Do you have any inflammatory disease such as arthritis or rheumatism?	Yes	No
12.	Do you have any blood disorders such as anemia, leukemia, etc.?	Yes	No
13.	Have you ever bled excessively after being cut or injured?	Yes	No
14.	Are you diabetic?	Yes	No
15.	Do you have asthma?	Yes	No
16.	Do you have epilepsy or seizure disorders?	Yes	No
17.	Do you or have you had venereal disease?	Yes	No
18.	Do you have AIDS? (HIV positive)	Yes	No
19.	Have you ever had hepatitis?	Yes	No
20.	Do you or have you had TB?	Yes	No
21.	Do you smoke?	Yes	No
22.	Are you pregnant or do you suspect you may be?	Yes	No
23.	Do you have any disease, condition or problem not listed? If so, explain _____	Yes	No
24.	Is there anything else we should know about your health that we have not covered on this form?	Yes	No

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT SIGNATURE _____ DATE _____