Welcome!

John J. Metz, DMD, MS

Medical & Dental Health History Form

Patient Name ______________________ SSN ______________ Date of Birth ________

Home Phone Number ______________ Cell Number ______________

Address ____

City ______________________ State __________ Zip ______________

Email ____

Occupation ____

Emergency Contact (name & phone number) ______________________________

____

Health History: Do you have, or have you ever had, any of the following conditions:

Yes	No		Yes	No	
☐	☐	Food/Drug Allergies	☐	☐	High/ Low Blood Pressure
☐	☐	Anemia	☐	☐	Infectious Diseases: (Circle)
☐	☐	Asthma			Herpes HIV Tuberculosis Hepatitis
☐	☐	Artificial Joints/Valves	☐	☐	Jaundice
☐	☐	Bleeding Problems	☐	☐	Kidney Disease
☐	☐	Cancer / Chemotherapy	☐	☐	Liver Disease
☐	☐	Cleft Lip & Palate	☐	☐	Pregnant/Nursing
☐	☐	Delayed Speech Development	☐	☐	Psychiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Rheumatic Fever
☐	☐	Diabetes	☐	☐	Seizures
☐	☐	Emotional Disturbances	☐	☐	Sickle Cell Anemia
☐	☐	Fainting Spells	☐	☐	Other ______________
☐	☐	Hearing Loss/Impairment			______________
☐	☐	Heart Condition			______________

CONTINUED ON BACK

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Are you currently seeing a physician? ________ Why? ____________________

Physician's Name: ____________________

Are you taking any medications? ☐ Yes ☐ No If yes, please list:

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Have you ever been hospitalized? ☐ Yes ☐ No If yes, please explain:

____

Dental Health:

Yes	No	
☐	☐	Have you ever had a toothache?
☐	☐	Have you ever received a blow or injury to your teeth?
☐	☐	Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ)?
☐	☐	Does brushing cause your gums to bleed?
☐	☐	Ever had any unhappy dental experience?

Why are you here today? (Main orthodontic concern) ____________________

____

When was your last dental appointment? ____________

How have you reacted to past medical or dental procedures?

☐ Very good ☐ Moderately ☐ Moderately poor ☐ Very poor

Do you think there is anything wrong with your teeth? ☐ Yes ☐ No If yes, please explain:

____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature ____________________ Date ____________