HEALTH HISTORY

PEAK ORTHODONTICS

Patient Full Name: _____

Indicate which of the following you HAVE /HAD (**circle "yes" or "no"** to each item)

Have you been under the care of a medical doctor during the past two years? ..... **YES** **NO**
Physician's Name: _____Phone #: _____
Address_____City_____

Have you been a patient in the hospital during the past two years? ..... **YES** **NO**
If yes, please explain: _____
Are you taking any medication or drugs currently? ..... **YES** **NO**
If yes, please list: _____
Are you sensitive or allergic to any medication or anesthetics? ..... **YES** **NO**
When you walk upstairs, or take a walk, do you ever have to stop because of pain in your chest? ..... **YES** **NO**
Do your ankles swell during the day? ..... **YES** **NO**
Do you ever wake up from sleep and feel short of breath? ..... **YES** **NO**
Have you lost or gained more than 10 pounds in the past year? ..... **YES** **NO**
If yes, please list: _____ **YES** **NO**
Are you on a special diet? ..... **YES** **NO**
If yes, please list: _____
Are you having tooth pain or discomfort currently? ..... **YES** **NO**
If yes, please list: _____
Do you have frequent headaches? ..... **YES** **NO**
If yes, is it **During the day**, **Afternoon**, **Evening**, or **All Day**? _____

ADD/ADHD.....	**YES**	**NO**	Development Disabled...	**YES**	**NO**	Nervousness.....	**YES**	**NO**
Heart Murmur.....	**YES**	**NO**	Stroke.....	**YES**	**NO**	Latex Allergy.....	**YES**	**NO**
Mitral Valve Prolapse...	**YES**	**NO**	Cancer.....	**YES**	**NO**	Nickel Allergy.....	**YES**	**NO**
Rheumatic Fever.....	**YES**	**NO**	Chemotherapy.....	**YES**	**NO**	Ulcers.....	**YES**	**NO**
High Blood Pressure...	**YES**	**NO**	Radiation therapy...	**YES**	**NO**	Tumors.....	**YES**	**NO**
Heart Disease or Attack	**YES**	**NO**	Asthma.....	**YES**	**NO**	Diabetes.....	**YES**	**NO**
Angina Pectoris.....	**YES**	**NO**	Hay Fever.....	**YES**	**NO**	Liver Disease.....	**YES**	**NO**
Artificial Joints (knee)....	**YES**	**NO**	Allergies or Hives....	**YES**	**NO**	Tuberculosis.....	**YES**	**NO**
Artificial Heart Valve....	**YES**	**NO**	Sinus Trouble.....	**YES**	**NO**	Hepatitis A (infection)	**YES**	**NO**
Heart Pacemaker.....	**YES**	**NO**	Chronic Cough.....	**YES**	**NO**	Hepatitis B (Serum)	**YES**	**NO**
Heart Surgery.....	**YES**	**NO**	Emphysema.....	**YES**	**NO**	Venereal Disease...	**YES**	**NO**
Heart Failure.....	**YES**	**NO**	Cold Sores/Fever blisters...	**YES**	**NO**	A.I.D.S	**YES**	**NO**
Heart Disease.....	**YES**	**NO**	Fainting/Dizzy spells.....	**YES**	**NO**	H.I.V. Positive.....	**YES**	**NO**
Arteriosclerosis.....	**YES**	**NO**	Seizures/Epilepsy.....	**YES**	**NO**	Blood Transfusion....	**YES**	**NO**
Arthritis.....	**YES**	**NO**	Thyroid Problems.....	**YES**	**NO**	Anemia.....	**YES**	**NO**
Rheumatism.....	**YES**	**NO**	Glaucoma.....	**YES**	**NO**	Sickle Cell Disease....	**YES**	**NO**
Cortisone Medication...	**YES**	**NO**				Bruise Easily.....	**YES**	**NO**

Do you have, or have you had, any disease, condition, or problem not listed?
If yes, please list: _____
FOR WOMEN ONLY: Are you pregnant?.....**YES** **NO** Due Date: _____ are you nursing?..... **YES** **NO**
Are you taking birth control pills?.....**YES** **NO**

I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

1. The undersigned hereby authorizes Peak Orthodontics to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Parent Signature _____ Date: _____

REVIEWED BY: _____ Date: _____