



Parisi Orthodontics

charting the course to exceptional smiles

Medical History

Patient Name: _____ Date of Birth: _____

Physician: _____ Date of last physical: _____

Have there been any changes in your general health in the last year? Yes / No

If yes, what? _____

Are you currently being treated by a physician for any reason? _____

If yes, what? _____ By whom? _____

Have you ever been hospitalized for any illness, accident or surgery? Yes / No

If yes, when and why? _____

Have you had tonsils and/or adenoids removed? Yes / No

If yes, when and why? _____

Are you allergic to any drug or other substances? Yes / No

If yes, what? _____

Females: Are you, or could you possibly be pregnant? Yes / No

Please circle all conditions that apply

Heart murmur

Heart surgery

Rheumatic/Scarlet Fever

Heart Pacemaker

Artificial Heart Valve

Artificial Joints

High/Low Blood Pressure

Shortness of Breath

Implants of Any Kind

Hives/Rash

TMJ Problems

Frequent Headaches

Depression

Thyroid disorder

Sinus Trouble

Asthma

Tuberculosis

Bronchitis

Hay Fever/Allergies

Epilepsy

Fainting

Aids/HIV

Emotional Problems

Anxiety

Diabetes

STD

ADD/ADHD

Is there any condition/problem or other information that you think would be helpful for us to know?

PRINT patient/parent/guardian

SIGNATURE

Today's Date