MEDICAL HISTORY

Brodie L. Bowman, DMD
Specialist in Orthodontics & Dentofacial Orthopedics
CHILDREN + TEENS + ADULTS

Patient's Name ______________________ Date ______________
Dentist's Name ______________________ Date of Last Dental Exam ______________
Physician's Name ______________________ Date of Last Physical Exam ______________

Allergies or reactions to any of the following:

Y __ N __ Aspirin, Ibuprofen or Tylenol
Y __ N __ Barbiturates
Y __ N __ Codeine or other narcotics
Y __ N __ Latex
Y __ N __ Local anesthetics
Y __ N __ Metals
Y __ N __ Penicillin or other antibiotic
Y __ N __ Plastic or vinyl
Y __ N __ Sedatives
Y __ N __ Sleeping pills
Y __ N __ Sulfa drugs
Y __ N __ Other______________

Medications:

Please list medications, nutrient supplements, herbal medications & non-prescription medicines currently being taken:

Medication	Taken For

Now or in the past , has the patient had:

Y__N__ Adenoids or tonsils removed
Y__N__ Arteriosclerosis (hardening of the arteries)
Y__N__ Asthma, hay fever, sinus trouble or hives
Y__N__ Autoimmune disorders or immune system problems
Y__N__ Bleeding or bruising easily
Y__N__ High or low blood pressure - please circle
Y__N__ Cancer, tumor, chemotherapy or radiation treatment
Y__N__ Chronic fatigue
Y__N__ Current pregnancy
Y__N__ Depression or other mental health disturbance
Y__N__ Diabetes
Y__N__ Dizziness
Y__N__ Epilepsy or other seizure disorder
Y__N__ Fibromyalgia
Y__N__ General anesthesia
Y__N__ Hearing impairment
Y__N__ Heart problems (murmur, irregular heartbeat, valve defect or replacement, pacemaker, palpitations)
Y__N__ Frequent coughs, colds, or sore throats
Y__N__ Hemophilia
Y__N__ Hepatitis, AIDS, or HIV positive
Y__N__ Injury to face, neck, mouth or teeth - please circle
Y__N__ Insomnia
Y__N__ Jaw joint surgery
Y__N__ Kidney or liver problems
Y__N__ Meniere's disease
Y__N__ Multiple sclerosis
Y__N__ Muscular dystrophy
Y__N__ Nighttime breathing problems (snoring or sleep apnea)
Y__N__ Nervousness
Y__N__ Neuralgia
Y__N__ Osteoarthritis (stiff or swollen joints)
Y__N__ Osteoporosis
Y__N__ Parkinson's disease
Y__N__ Prior orthodontic treatment
Y__N__ Psychiatric care
Y__N__ Rheumatic fever
Y__N__ Rheumatoid arthritis
Y__N__ Scarlet fever
Y__N__ Skin disorder
Y__N__ Speech difficulties
Y__N__ Stroke or heart attack
Y__N__ Tuberculosis
Y__N__ Wisdom teeth extraction
Y__N__ Birth defects or hereditary problems
Y__N__ Endocrine or thyroid problems
Y__N__ Stomach ulcer or hyperacidity
Y__N__ Polio, mononucleosis or pneumonia
Y__N__ Vision problems
Y__N__ Loss of weight recently, poor appetite
Y__N__ Eating disorder (anorexia or bulimia)
Y__N__ Chest pain, shortness of breath or swelling ankles
Y__N__ Frequent or severe headaches
Y__N__ Other condition

Emergency Contact ______________________ Relationship______________ Phone # ______________

Patient / Parent Signature ______________________ Today's Date ______________

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