Patient Medical History

Patient Name:	_____	DOB: ____/____/_____	Date:	____/____/_____	
Legal Guardian:	_____	DOB: ____/____/_____	Relationship to patient:	_____	
Legal Guardian:	_____	DOB: ____/____/_____	Relationship to patient:	_____	

Our network provides care in dental, orthodontics and vision. Full body health shares an important interrelationship with dental and eye health. Please answer each of the following questions, for the patient, as accurately as possible. Thank you!

Has the patient ever been hospitalized for any reason? ☐ Yes ☐ No

Please describe:_____

Has the patient had surgery for any reason? ☐ Yes ☐ No

Please describe:_____

Constitution:	☐ Nutritional Deficiency	☐ Weight Gain	☐ Weight Loss	☐ Loss of Taste	
	☐ Cancer				☐ None
Psychiatric:	☐ ADHD	☐ Psychiatric Care	☐ Depression	☐ Anxiety	☐ None
Congenital Disorder:	☐ Cerebral Palsy	☐ Cleft Palate	☐ Cleft Lip	☐ Down Syndrome	
	☐ Speech Problems				☐ None
Cardiovascular:	☐ Fainting	☐ Heart Murmur	☐ High Blood Pressure	☐ Low Blood Pressure	
	☐ Heart Disease				☐ None
Endocrine:	☐ Diabetes Type 1	☐ Diabetes Type 2	☐ Thyroid Dysfunction	☐ Excessive Thirst	☐ None
Hematology:	☐ Anemia	☐ Bleeding Problems	☐ Sickle Cell Anemia	☐ High Cholesterol	
	☐ AIDS/HIV	☐ Leukemia			☐ None
Integumentary:	☐ Chicken Pox	☐ Cold Sores/Blisters	☐ Rosacea	☐ Shingles	☐ None
Genitourinary:	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Kidney Disease	
	☐ Herpes				☐ None
Musculoskeletal:	☐ Head Injury	☐ Neck Injury	☐ Orthopedic Problems	☐ Tetanus	☐ None
Neurological:	☐ Autism	☐ Brain Injury	☐ Convulsions/Seizures	☐ Epilepsy	
	☐ Intellectual Disability	☐ Developmental Delay	☐ Frequent Headaches		☐ None
Pulmonary:	☐ Asthma	☐ Breathing Problems			☐ None
Rheumatology:	☐ Arthritis	☐ Rheumatoid Arthritis	☐ Psoriatic Arthritis	☐ Multiple Sclerosis	
	☐ Autoimmune Disorder				☐ None
Ocular History:	☐ Crossed/Lazy Eye	☐ Corneal Disease	☐ Injury/Trauma	☐ Retinal Disease	
	☐ Retinal Detachment	☐ Cataracts	☐ Glaucoma	☐ Macular Degeneration	
	☐ Diabetic Retinopathy	Retinitis Pigmentosa			☐ None

Does the patient have any other medical, dental, or ocular conditions not previously noted? ☐ Yes ☐ No

Please describe:_____

Is the patient allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Amoxicillin ☐ Sulfa ☐ Codeine ☐ Latex ☐ Pollen ☐ Local Anesthetic

Does the patient have any other allergies not previously noted? ☐ Yes ☐ No

Please describe:_____

Is the patient taking any medications, pills, or drugs? ☐ Yes ☐ No

Please describe:_____

Has anyone in the patient's family (blood relative) ever had any of the following?

* Note relation to patient: M- Mother, F- Father, U- Uncle, A-Aunt, S- Sister, B- Brother, GF- Grandfather, GM- Grandmother

☐ Diabetes:_____ ☐ Heart Condition:_____ ☐ High Blood Pressure:_____ ☐ Bleeding Disorders:_____

☐ Glaucoma:_____ ☐ Cataracts:_____ ☐ Cornea Disease:_____ ☐ Macular Degeneration:_____

☐ Diabetic Retinopathy:_____ ☐ Retinal Detachment:_____ ☐ Retinitis Pigmentosa:_____ ☐ Crossed/Lazy Eye:_____

Please list any other family health or eye problems:

Please describe:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the practice of any changes in medical history or medications.

_____ _____ _____/_____/_____

Printed Name Patient Signature (or guardian if a minor) Date