DAVID ORTHODONTICS

CONFIDENTIAL DATE: _____

VISITING PATIENT MEDICAL DENTAL HISTORY FORM

Last Name: _____ Legal First Name: _____
Birth date: (dd-mm-yy) _____ Preferred Name: _____
Mailing Address: _____
_____
Home Phone: _____ Cell Phone: _____
Local Phone: _____
Person To Contact in Emergency: _____
Orthodontist's Name: _____
Orthodontist's Address: _____
_____
Orthodontist's Phone: _____

MEDICAL INFORMATION

Physician's Name: _____ Date of last physical exam: _____

For the following questions mark **yes, no or don't know (d/k)**

	yes	no	d/k
1. Have you ever been hospitalized for any operation or illness? If so, for what? _____	☐	☐	☐
2. Do you have (or had) any of the following diseases or problems:			
a) heart disease, rheumatic or scarlet fever, heart murmurs or heart valve replacements?	☐	☐	☐
b) hepatitis, jaundice, mononucleosis, or pneumonia?	☐	☐	☐
c) fainting spells, dizziness, or seizures?	☐	☐	☐
3. Do you wear contact lenses?	☐	☐	☐
4. Have you had radiation therapy for any disease of the head or neck?	☐	☐	☐
5. Are you pregnant or do you think you might be?	☐	☐	☐
6. Are you allergic to latex, nickel, red food dye, aspirin, penicillin or any other drug? _____	☐	☐	☐
7. Do you have any disease, condition or problem not listed above that we should know about? _____	☐	☐	☐
8. Please list all the medications that you are currently taking. _____			
9. Are you currently under the care of a physician?	☐	☐	☐

_____
_____
_____
_____

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____

Dr. Alexis D. David Inc.
Certified Specialist in Orthodontics

Nanaimo | Ladysmith | Duncan
T: 250.716.0611 | 250.245.0677 | 778.455.0611
davidortho.com