To save time, complete this at your leisure and bring with you to the examination appointment.

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Telephone 530-345-0600
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Medical History

Patient's name: _____ Date of birth: / /
First Middle Initial Last D M Y

Physician name: _____ Physician's city/phone _____

Daily medications used:
None ☐
Yes ☐ List: _____

Current medical treatment:
None ☐
Yes: ☐ Describe: _____

History of serious illness, injury or surgery:
None ☐
Yes ☐ Describe: _____

Y ☐	N ☐	Heart disease or abnormality?	Y ☐	N ☐	Cancer?
Y ☐	N ☐	History of rheumatic fever?	Y ☐	N ☐	Radiation treatment?
Y ☐	N ☐	Heart murmur?	Y ☐	N ☐	Herpes or other STD?
Y ☐	N ☐	Diabetes?	Y ☐	N ☐	AIDS or other immune system disorder?
Y ☐	N ☐	Hepatitis?	Y ☐	N ☐	Mouth breathing?
Y ☐	N ☐	Anemia?	Y ☐	N ☐	Frequent colds or ear infections?
Y ☐	N ☐	Prolonged Bleeding Tendency?	Y ☐	N ☐	Frequent or severe headache?
Y ☐	N ☐	Arthritis?	Y ☐	N ☐	Depression, bipolar disorder?
Y ☐	N ☐	Thyroid or other metabolic problem?	Y ☐	N ☐	ADD or ADHD?

List any food or drug allergies: _____

Please use this space to add anything that may be important about current or previous medical conditions.

Growth status is sometimes important in planning orthodontic care. If patient is under 20 years of age, please provide the following growth information.

Patient's height: _____ Mother's height: _____ Fathers height: _____

Boys: Voice changed? Y ☐ N ☐ If yes, age of start of voice change: _____

Girls: Menstrual period? Y ☐ N ☐ If yes, age of first menses: _____

Signature: _____ Date: _____

Signature of parent or guardian required for patient less than 18 years of age.