



John J. Metz DMD, MS

Medical and Dental Health History Form

Patient Name: _____ SSN: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer & Phone Number: _____

Emergency Contact: (Name & Phone Number) _____

Health History

Do you have, or have you ever had, any of the following conditions:

Yes	No		Yes	No	
()	()	Food/Drug Allergies	()	()	High/ Low Blood Pressure
()	()	Anemia	()	()	Infectious Diseases: (Circle)
()	()	Asthma			Herpes, HIV
()	()	Artificial Joints/Valves			Tuberculosis, Hepatitis
()	()	Bleeding Problems	()	()	Jaundice
()	()	Cancer/ Chemotherapy	()	()	Kidney Disease
()	()	Cleft Lip & Palate	()	()	Liver Disease
()	()	Delayed Speech Development	()	()	Pregnant/Nursing
()	()	Difficulty Breathing	()	()	Psychiatric Problems
()	()	Diabetes	()	()	Rheumatic Fever
()	()	Emotional Disturbances	()	()	Seizures
()	()	Fainting Spells	()	()	Sickle Cell Anemia
()	()	Hearing Loss/Impairment	()	()	Other _____
()	()	Heart Condition			_____

CONTINUED ON BACK



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Are you currently seeing a physician? _____ Why? _____

Physician's Name: _____

Are you taking any medications? () Yes () No If yes, please list

1. _____ 3. _____

2. _____ 4. _____

Have you ever been hospitalized? () Yes () No If yes, please explain

Dental Health

Yes No

() () Have you ever had a toothache?

() () Have you ever received a blow or injury to your teeth?

() () Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ)?

() () Does brushing cause your gums to bleed?

() () Ever had any unhappy dental experience?

Why are you here today? (Main orthodontic concern) _____

When was your last dental appointment? _____

How have you reacted to past medical or dental procedures?

() Very good () Moderately good () Moderately poor () Very poor

Do you think there is anything wrong with your teeth? () Yes () No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

X _____

Patient Signature

_____ Date