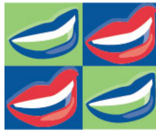

PARKER ORTHODONTICS
your smile · inspired

500 Kenwood Avenue
Delmar, NY 12054
518.439.9339 Phone
info@parkerortho.com

DAMON SYSTEM
More than straight teeth

Member American Association of Orthodontists

Medical Health History

PATIENT NAME:____**DATE:**______________

PATIENT MEDICAL HISTORY

PHYSICIAN:_______________________OFFICE PHONE:____________________________

DATE OF LAST EXAM:_____________MEDICAL ALERT:______________________________

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3. Are you taking any medicine? If yes, what medication(s) are you taking? _________________________	❑	❑
4. Do you use tobacco?	❑	❑
5. Are you wearing contact lenses?	❑	❑

Comments:____________________

____

6. Are you allergic to or have you had any reactions to the following?

YES	NO		YES	NO	
❑	❑	Local Anesthetics	❑	❑	Barbiturates
❑	❑	Aspirin	❑	❑	Penicillin or other Antibiotics
❑	❑	Sedatives	❑	❑	Sulfa Drugs
❑	❑	Iodine	❑	❑	Other

7. WOMEN ONLY:	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

8. Do you have or have you had any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/Allergies
❑	❑	Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Diseases	❑	❑	Hepatitis or Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS of HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Other________
❑	❑	Thyroid Problem	❑	❑	Stomach Troubles/Ulcers			

COMMENTS:____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE:____
PATIENT, PARENT OR GUARDIAN DATE

SIGNATURE-Michael Parker, DDS, MS:______________________________________
DATE

***FILL OUT FORM ON OTHER SIDE →

Patient Dental History

PATIENT NAME____

Patient's Dentist:____________________ Date of Last Dental Visit:____________________

Any X-Rays taken? ❑ NO ❑ YES: what type?______________________________

Dental Specialists (Orthodontist, Periodontist, Oral Surgeon, etc..) who treated you (give names, treatments & dates):______________________________

Chief Orthodontic Complaint (Reason for this visit):______________________________

How many times per day do you brush your teeth? 1 ❑ 2 ❑ 3+ ❑ How many times per day do you floss 0 ❑ 1 ❑ +2 ❑

Question	YES	NO	
1. Any injuries to face, mouth or teeth? -------------------	❑	❑	If yes, explain________________
2. Ever sucked thumb or finger(s)? -------------------------	❑	❑	Until what age________________
3. Speech problems?---	❑	❑	
4. Breathes predominately through the mouth?-------------	❑	❑	
5. Any missing or extra **permanent** teeth?------------------	❑	❑	
6. Any teeth removed by the dentist-------------------------	❑	❑	If yes which________________
7 . Clench or grinds teeth?-------------------------------------	❑	❑	
8. Congenital abnormalities?----------------------------------	❑	❑	
9. Had psychological counseling?---------------------------	❑	❑	
10. Tonsil or adenoids removed?-----------------------------	❑	❑	If yes at what age?________________
11. Would the patient mind wearing braces?----------------	❑	❑	
12. Difficulty/apprehensive toward dental visits?-----------	❑	❑	
13. Has patient reached puberty?-----------------------------	❑	❑	If yes, at what age________________
14. Frequent headaches?---------------------------------------	❑	❑	
15. Are your teeth sensitive to hot or cold liquids or food?	❑	❑	
16. Do you feel pain in any of your teeth?------------------	❑	❑	
17. Have you experienced any of the following problems in your jaw? a) Clicking------------------------------	❑	❑	
b) Difficulty in opening or closing---	❑	❑	
c) Difficulty in chewing?--------------	❑	❑	

18. Approximate growth last 6 months ________________

19.Height Patient______ Mother______ Father________

20. Patient's mouth resembles: ❑ Mother ❑Father

Comments:____

____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE:____

PATIENT, PARENT OR GUARDIAN DATE

SIGNATURE- Michael Parker, DDS, MS:______________________________

DATE