Justin Pagan, DDS, MSD
Orthodontic Specialist

MEDICAL HISTORY

Patient Name:

Physician:

Date of Last Visit:

Physician Address:

Physician Phone No.

Do you have any of the following medical conditions:

_____If yes, describe

		Yes	No
1	Abnormal bleeding/Hemophilia	☐	☐
2	Diabetes	☐	☐
3	Hepatitis/Liver problems	☐	☐
4	Pneumonia	☐	☐
5	Anemia	☐	☐
6	Dizziness	☐	☐
7	Herpes	☐	☐
8	Prolonged Bleeding	☐	☐
9	Arthritis	☐	☐
10	Epilepsy	☐	☐
11	High Blood Pressure	☐	☐
12	Radiation/Chemotherapy	☐	☐
13	Asthma or Hayfever	☐	☐
14	Gastrointestinal Disorders	☐	☐
15	HIV / Aids	☐	☐
16	Rheumatic Fever	☐	☐
17	Bone Disorders	☐	☐
18	Heart Problems	☐	☐
19	Kidney problems	☐	☐
20	Tuberculosis	☐	☐
21	Congenital Heart Defect	☐	☐
22	Heart Murmur	☐	☐
23	Nervous Disorders	☐	☐
24	Tumor or Cancer	☐	☐
25	Are you pregnant?	☐	☐
26	Are there any medical conditions we have not discussed that you feel we should be aware of? If yes, describe:	☐	☐
27	Have you ever been involved in a serious accident? If Yes, describe:	☐	☐

Are You:

_____If yes, describe

		Yes	No
28	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	☐	☐
29	often exhausted or fatigued	☐	☐
30	experiencing frequent headaches	☐	☐
31	a smoker, smoked previously or use smokeless tobacco	☐	☐
32	currently taking any medications. If yes, describe:	☐	☐

Patient / Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____