Strouse ORTHODONTICS

HEALTH HISTORY FORM - ADULT

Patient's Name: _____ Nickname: _____ DOB: _____

Mailing Address: _____

Email: _____ Phone: _____

Occupation: _____ Employer's Name: _____ Employer's Zip Code: _____

Spouse or Closest Relative's Name: _____ DOB: _____

Relationship to Patient: _____ Mailing Address: _____

Email: _____ Phone: _____

Occupation: _____ Employer's Name: _____ Employer's Zip Code: _____

How did you hear about Dr. Strouse? [ ] Google [ ] Social Media [ ] Word-of-Mouth [ ] Referred by: _____

Health Care Professionals:

Dentist Name: _____ Dentist's Phone Number: _____

Dentist Office Address: _____ Last Dental Cleaning Date: _____

Physician's Name: _____ Physician's Phone Number: _____

Medical History - Any History of the following problems?

Y	N	Abnormal Bleeding	Y	N	Hemophilia	Y	N	Previous Orthodontics
Y	N	Allergic to Metal	Y	N	Cancer	Y	N	Pain in the Jaw Joint
Y	N	Asthma	Y	N	Epilepsy	Y	N	Tonsils Removed
Y	N	Diabetes	Y	N	HIV Positive	Y	N	Are you pregnant?
Y	N	Kidney Problems	Y	N	Liver Problems	Y	N	Previous Injury to face or teeth? If yes, explain:
Y	N	Mitral Valve Prolapse	Y	N	Operations			_____
Y	N	Tuberculosis	Y	N	Heart Murmur			_____
Y	N	Heart Defect	Y	N	Rheumatic Fever			_____
Y	N	Scarlet Fever	Y	N	**Are you allergic to latex?**			_____

Allergies to medications (please list): _____

Current medications (please list): _____

Any existing medical or dental problems? _____

Reason for wanting Orthodontic Treatment: _____

_____ Patient's Printed Name

_____ Patient's Signature

_____ Today's Date