CHAPMAN ORTHODONTICS

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www.drchapmanorthodontics.com

Orthodontics of Central Indiana, P.C.

Patient's Name: _____ Date: _____

MEDICAL HISTORY

Physician's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Date of Last Physical Exam _____ Blood Pressure: _____

Please check "yes" or "no" if patient has any history of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Rheumatic Fever	☐	☐	Muscle Disease	☐	☐	Dry Mouth	☐	☐	Dizzy Spells
☐	☐	Heart Disease	☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Severe Headaches
☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐	Drug Allergies	☐	☐	Sinus Condition
☐	☐	Bleeding Disorder	☐	☐	Bone Disorder	☐	☐	Cancer	☐	☐	Epilepsy
☐	☐	Lung Disease	☐	☐	Skin Disease	☐	☐	Back/Neck Pain	☐	☐	Depression
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Back/Neck Injuries	☐	☐	Drug Dependence
☐	☐	Intestinal Ulcers	☐	☐	Thyroid Disorder	☐	☐	Artificial Joints	☐	☐	Counseling
☐	☐	Liver Disorder	☐	☐	Hormonal Disorder	☐	☐	Tonsillectomy	☐	☐	Severe Trauma
☐	☐	Bowel Disorder	☐	☐	Hepatitis	☐	☐	Adenoidectomey	☐	☐	Weight Loss/Gain
☐	☐	Kidney Disorder	☐	☐	HIV / Aids	☐	☐	Ear/Nose Surgery	☐	☐	Allergies
☐	☐	Bladder Disorder	☐	☐	Bisphosphonate Treatment	☐	☐	Ear Tubes	☐	☐	Latex Allergies

OTHER INFORMATION

Please explain any answers of "yes" to the above questions (include additional sheet of paper if needed):

_____

_____

List all drugs now taken and reason (include additional sheet of paper if needed):

_____

_____

List all hospitalizations with dates (include additional sheet of paper if needed):

_____

_____

Signature of Custodial Parent/Guardian/Patient	Relationship to Patient	Date
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PREMEDICATION ASSESSMENT

Certain medical conditions require antibiotic premedication for involved dental and orthodontic procedures. Such conditions may include:

Artificial Heart Valves	Severe Congenital Heart Disease
Previous Bacterial Endocarditis	Surgical Shunts
Rheumatic Heart Disease	Artificial Joints

	YES	NO
Do you have any medical conditions that require premedication?	☐	☐

If yes, which condition do you have? _____

If yes, which medication do you take? _____

What is the dosage and when do you take it? _____

LATEX ALLERGY ASSESSMENT

Due to the increasing incidence of latex allergies and the possible associated problems, we would like to assess your possible sensitivity. To help in this evaluation, please answer the following health related questions.

WE DO NOT USE LATEX GLOVES; HOWEVER, SOME SUPPLIES MAY INCLUDE LATEX MATERIALS

YES	NO	
☐	☐	Do you have a confirmed latex allergy?
☐	☐	Does any other family member living in the same household have a confirmed latex allergy?
☐	☐	Do your lips swell after blowing up a balloon?
☐	☐	Do you have allergies to bananas, kiwis, chestnuts, or avocados?
☐	☐	Have you had multiple surgeries?

If you have a known latex allergy, or at some point should develop a latex allergy, please do the following:

- Inform our office of the allergy so that your chart may be amended.
- Try to schedule your appointments during the first part of the day when any airborne allergy particles are at the lowest levels.

Your cooperation is greatly appreciated, and if you should have any questions, please do not hesitate to ask.

TUBERCULOSIS RISK ASSESSMENT

Due to the increasing incidence of infectious Tuberculosis (TB) and the associated health risk to others, Government regulations now require that all patients entering a health care facility be screened for exposure to Tuberculosis.

To help in this evaluation, please answer the following health related questions:.

YES	NO	
☐	☐	Do you have active Tuberculosis (TB)?
☐	☐	Does any other family member living in the same household have active TB?
☐	☐	Have you ever been vaccinated against TB?
☐	☐	Have you ever had a positive reaction to a TB skin test?

Have you recently had any of the following signs and symptoms of TB infection?:

YES	NO	
☐	☐	Persistent cough lasting 3 weeks or longer?
☐	☐	Coughing up blood?
☐	☐	Weight loss (not by diet)?
☐	☐	Night sweats?
☐	☐	Fever?