DRWEISS
ORTHODONTIST

Adult Medical History Form

Name
Today's Date
Birthdate
Address
Postal Code
Home Phone
Business Phone
Cell Phone
Email
Occupation

Name of physician
Phone Number
Family Dentist
Date of Last Checkup
Is there any more dental work to be done?
Did your dentist send any information or X-rays with you?
Whom may we thank for referring you to our office?

How would you describe your General Health? ◯ Good ◯ Fair ◯ Poor
Have you ever had any serious illnesses or hospitalizations?
Do you have any allergies? (Penicillin, pollens, dusts, etc.)?
Are you taking any medication now (pills, drugs, injections etc.)?

Have you ever had any of the following?

Anemia	◯ Yes	◯ No	Heart Disease	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No	Heart murmur	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No
Hepatitis	◯ Yes	◯ No	Liver or Kidney Disease	◯ Yes	◯ No	Pneumonia	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Blood disorders	◯ Yes	◯ No
Hives	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No	Aids/ Autoimmune diseases	◯ Yes	◯ No

Why have you made today's appointment?

Our office understands the importance of protecting your personal information. To help you understand how we do that, you will have the opportunity to review our information practices at your first appointment.