

Duncan Y. Brown & Dana Van Elslande
Orthodontists*
 Suite 290 10655 Southport Rd. S.W.
 Calgary, Alberta
 T2W 4Y1

Medical and Dental History Summary

Patient's First Name:

Patient's Last Name:

Address:

Date of Birth:

Hm.Phone:

E-mail:

Dentist:



**Medical and Dental History:
 Tell Us About Yourself!**

All Information will be treated as CONFIDENTIAL. Please advise us of any changes!

	Yes	No	Notes
Are You in Good General Health?	<input type="radio"/>	<input type="radio"/>	
Are you currently being treated by a Medical Doctor?	<input type="radio"/>	<input type="radio"/>	

Medical Doctor's Name _____

When was your last visit to your Medical Doctor? Please describe.

Summary of Medical History: **Please check where appropriate**

History of Major Illness	<input type="radio"/>	<input type="radio"/>
History of Heart Murmur, Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
History of Liver Disease	<input type="radio"/>	<input type="radio"/>
History of Bleeding	<input type="radio"/>	<input type="radio"/>
History of Medications	<input type="radio"/>	<input type="radio"/>
Frequent Colds	<input type="radio"/>	<input type="radio"/>
Sore Throats	<input type="radio"/>	<input type="radio"/>
Ear Infections	<input type="radio"/>	<input type="radio"/>
Frequent Sinusitis	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>
History of Asthma	<input type="radio"/>	<input type="radio"/>
Autoimmune Diseases	<input type="radio"/>	<input type="radio"/>

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	Yes	No	Notes
Blood Disorders	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Low Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Smoking	<input type="radio"/>	<input type="radio"/>	
Epilepsy	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	
Aids, HIV, Hepatitis A,B,C	<input type="radio"/>	<input type="radio"/>	

Are you presently taking medications? Please List. Yes No

Have any other family members had orthodontic treatment? Yes No

Please, describe any prior orthodontic experience. Yes No

Have you had TMD (jaw joint) problems in the past? Yes No

Do you have "clicking or locking" of the jaw joints? Yes No

Do you have pain around the jaw joints or ears? Yes No

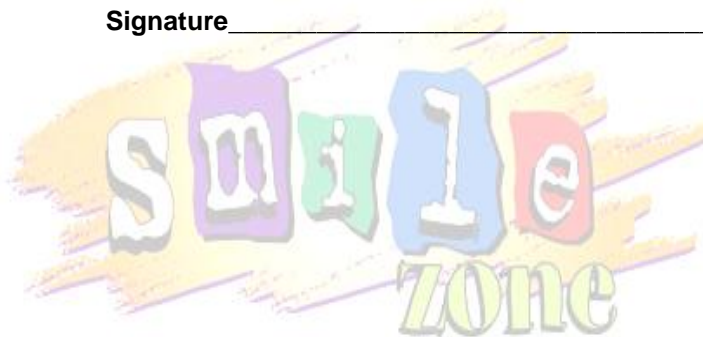
Have you been treated for a "jaw joint problem"? Yes No

Have you had a history of injuries to your face, lips, or teeth? Yes No

It is understood that the patient will inform our office in changes to their medical history as they occur so that we may update our records.

Thank You!

Signature _____



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