PAGAN
ORTHODONTICS

Justin Pagan, DDS, MSD
ORTHODONTIC SPECIALIST

MEDICAL HISTORY

Date of last visit _____

Name _____

Physician _____ Physician Phone _____

Physician Address _____

Do you have any of the following medical conditions:

_____If yes, describe

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

Are you

_____If yes, describe

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

If yes, describe _____

Patient / Guardian's Signature _____ Date _____

Doctor's Signature _____ Date _____