GLYNN ORTHODONTICS | Ellen J. Glynn, DDS MDS
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Health History

Patient Name:_____

Your health is very important to us. In order to provide excellent care, we need to be aware of your medical history and current health status. It is extremely important that you answer the following questions as accurately as possible. If you have any questions regarding the information requested, please feel free to ask Dr. Glynn or a member of the staff for assistance. All information will be kept confidential.

Have you been a patient in a hospital? Y N
Have you been under the care of a physician? Y N
Have you taken any prescription medication or drugs during the last year? Y N
Please list the medication or drugs. _____
Are you allergic to any medicine, latex, or nickel? Y N
Please list any allergies. _____

Please indicate whether you have had any of the following conditions:

Heart Murmur	Y N	Scarlet Fever	Y N	Arthritis	Y N	Congenital Heart Lesions	Y N
Heart Surgery	Y N	Emphysema	Y N	Stroke	Y N	Endocrine Disorder	Y N
Epilepsy	Y N	Diabetes	Y N	Fainting	Y N	Artificial Heart Valve	Y N
Tonsillitis	Y N	Ulcers	Y N	Bronchitis	Y N	High or Low Blood Pressure	Y N
Glaucoma	Y N	Allergies	Y N	Drug Addiction	Y N	Psychiatric Treatment	Y N
Tuberculosis	Y N	Anemia	Y N	Hepatitis	Y N	Artificial Joints	Y N
Asthma	Y N	Chest Pain	Y N	Blood Disorder	Y N	Sleeping Problems	Y N
Speech Problem	Y N	Growth Disorder	Y N	AIDS/HIV	Y N	Developmental Disorder	Y N
Hepatitis	Y N	Skin Rash/Hives	Y N	Rheumatic Fever	Y N	Mitral Valve Prolapse	Y N
Bleeding Problem	Y N	Liver Problem	Y N	Kidney Problem	Y N	Frequent Headaches	Y N

Are there any other health problems that we should know about? Y N
Do you smoke? Y N
Women, are you pregnant or nursing? Y N
Do you wear contact lenses? Y N

Have you had any injuries to your face, neck, jaws, or teeth? Y N
Do you have difficulty opening your mouth wide? Y N
Do your jaws ever click or pop? Y N
Do you have any TMJ problems? Y N

Have you had your tonsils and/or adenoids removed? Y N
Is there fluoride in your drinking water? Y N
Do you have any of the following habits? (circle)
Nail biting Lip biting Finger or thumb sucking Pencil biting Mouth breathing Grinding Clenching

Physician's Name and Contact Information: _____
_____

The above medical information is accurate and current to the best of my knowledge. I understand that it is very important to promptly report any changes in my medical or dental status.

Signature of patient, parent or guardian: _____ Date: _____

Reviewed by Dr. Glynn: _____ Date: _____