

**DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

TUBERCULOSIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	RESPIRATORY LUNG DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	ADD/ADHD	<input type="checkbox"/> YES <input type="checkbox"/> NO
ENDOCARDITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY TROUBLE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART CONDITION	<input type="checkbox"/> YES <input type="checkbox"/> NO	LOW BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART PACEMAKER	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEPATITIS (Type? _____)	<input type="checkbox"/> YES <input type="checkbox"/> NO	PSYCHIATRIC TREATMENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART ANGINA	<input type="checkbox"/> YES <input type="checkbox"/> NO	VENEREAL DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DRUG ADDICTION	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART ATTACK (CORONARY)	<input type="checkbox"/> YES <input type="checkbox"/> NO	HERPES (ORAL-COLD SORES)	<input type="checkbox"/> YES <input type="checkbox"/> NO	HEADACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO
MITRAL VALVE PROLAPSE	<input type="checkbox"/> YES <input type="checkbox"/> NO	BLOOD DISORDERS/BLEEDING PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	EARACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO
CONGENITAL HEART DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO	INFLAMMATORY RHEUMATISM	<input type="checkbox"/> YES <input type="checkbox"/> NO	JAW CLICKING	<input type="checkbox"/> YES <input type="checkbox"/> NO
ARTIFICIAL HEART VALVE	<input type="checkbox"/> YES <input type="checkbox"/> NO	ARTHRITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART SURGERY: DATE _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	ULCERS	<input type="checkbox"/> YES <input type="checkbox"/> NO	ALLERGIES TO METAL	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART MURMUR	<input type="checkbox"/> YES <input type="checkbox"/> NO	STROKE	<input type="checkbox"/> YES <input type="checkbox"/> NO	JAW PAIN	<input type="checkbox"/> YES <input type="checkbox"/> NO
RHEUMATIC FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	ANEMIA	<input type="checkbox"/> YES <input type="checkbox"/> NO	TONSILLITIS	<input type="checkbox"/> YES <input type="checkbox"/> NO
PROSTHETIC (ARTIFICIAL) JOINT	<input type="checkbox"/> YES <input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	EMOTIONAL PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO
X-RAY/RADIATION (CANCER) THERAPY	<input type="checkbox"/> YES <input type="checkbox"/> NO	EPILEPSY	<input type="checkbox"/> YES <input type="checkbox"/> NO	BLOOD TRANSFUSION	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	GLAUCOMA	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER: _____	
AIDS or HIV	<input type="checkbox"/> YES <input type="checkbox"/> NO	FAINTING SPELLS			

**MEMO:**

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I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. **THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE INFORMATION.**

Signature of Patient or Legal Guardian if patient is under 18.

Today's Date \_\_\_\_\_

\_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Signature of Orthodontist

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Update \_\_\_\_\_ Initial \_\_\_\_\_

Notes:

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