



garlockORTHODONTICS

303.627.6212 | 6020 S. GUN CLUB ROAD | SUITE E1 | AURORA, CO 80016

MEDICAL HISTORY  UPDATE

Patient Information (Información del Paciente)

- 1. Has either parent had orthodontic treatment? YES or NO
- 2. Have you had other Orthodontic Consults or Treatment? YES or NO  
If so, Where have you received other Orthodontic Consults or Treatment? \_\_\_\_\_
- 3. Are you satisfied with past orthodontic treatment? YES or NO

Medical History (Historial Médico)

- 4. Have there been any injuries to the face, mouth, teeth?  
If so, describe injuries \_\_\_\_\_
- 5. Have you experienced (check ones that apply):
  - Automobile accident       Bleed/Clotting Problems
  - Accidental Injury           Major/Minor surgery
  - Blood transfusion           Hyperactivity
- 6. Do you have a personal physician? YES or NO
- 7. Are you currently under the care of a doctor other than regular check-ups? YES or NO  
If yes, please explain: \_\_\_\_\_
- 8. Do you require premedication for dental treatment? YES or NO
- 9. Do you have a latex allergy/sensitivity?
- 10. Please list any allergies or drug sensitivity: \_\_\_\_\_
- 11. Are you taking any prescription drugs? YES or NO  
If yes, please list: \_\_\_\_\_

Medical Information, Have you ever been diagnosed or treated for (please check any that apply):

- History of major illness       Allergies       Smoker
  - Frequent colds                   Autoimmune disease       Epilepsy
  - Sore throats                       Blood disorder               Diabetes
  - Ear infections                     High blood pressure         Asthma
  - Frequent sinusitis               Low blood pressure
12. Please list any other contributing medical history: \_\_\_\_\_

**For women only (If male skip to 16)**

13. When was your first menstrual cycle?

14. Are you pregnant? YES or NO

15. Are you nursing? YES or NO

**Patient Dental History (*Historia Dental*)**

16. How frequently do you have dental check-ups?

- Twice a year                       Once a year  
 Only for emergencies       Never

17. When was patients last dental check-up? \_\_\_\_\_ (Month/Year)

18. Do you brush your teeth daily? YES or NO

19. Do you floss teeth daily? YES or NO

20. Do you use Supplemental Mouth Rinses?

21. Who is your general dentist? \_\_\_\_\_

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in mine or my child's medical status. I also authorize the dental staff to perform the necessary dental services.

X \_\_\_\_\_  
Signature of Patient / Parent / Guardian                      Date                      Relationship to Patient

**OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

X \_\_\_\_\_  
Signature of Doctor

Doctor Comments: