Wood Orthodontics - Steven C. Wood, DDS, MS
971 Hilltop Drive – Weatherford, TX 76086 – 817.599.5084

# MEDICAL HISTORY

*PLEASE PRINT and USE INK*

Patient Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Street City State Zip Area Code + Phone

Family Physician: _____
Name City Area Code + Phone Date of Last PHYSICAL

Please **CIRCLE** the appropriate answers.

Do you or have you ever had any of the following medical conditions?

| | | |
|---|---|---|
| Anemia (any type) | Yes | No |
| Arthritis (any type) | Yes | No |
| Artificial Heart Valves or Joints | Yes | No |
| Asthma or any Breathing Disorders | Yes | No |
| Bleeding or Blood Disorders | Yes | No |
| Blood Transfusions | Yes | No |
| Cancer / Tumors / Chemotherapy | Yes | No |
| Diabetes | Yes | No |
| Fainting / Epilepsy / Seizures | Yes | No |
| GI disorders, e.g. Celiac, Crohn's | Yes | No |
| Heart Murmur / other heart defect | Yes | No |
| Heart Surgery (any type) | Yes | No |
| Hepatitis (any type) | Yes | No |
| HIV+ or AIDS | Yes | No |
| Leukemia | Yes | No |
| Liver / Kidney / other organ problems | Yes | No |
| Low / High Blood Pressure | Yes | No |
| Lupus | Yes | No |
| Mitral Valve Prolapse | Yes | No |
| Osteoporosis / any bone disorders | Yes | No |
| Radiation Treatment | Yes | No |
| Rheumatic / Scarlet Fever | Yes | No |
| Stroke | Yes | No |
| Thyroid | Yes | No |
| Tuberculosis | Yes | No |
| Venereal Disease | Yes | No |

Please write any other unlisted medical condition(s) that you have / had:

_____

Are you allergic or have any reaction to any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Acetaminophen | Yes | No | Ibuprofen | Yes | No |
| Artificial Flavors | Yes | No | Jewelry/Metals | Yes | No |
| Aspirin | Yes | No | Latex | Yes | No |
| Codeine | Yes | No | Penicillin | Yes | No |
| Erythromycin | Yes | No | Sulfa Drugs | Yes | No |
| Food Dyes | Yes | No | Tetracycline | Yes | No |

Please list any other drugs/materials/items that you are allergic to:

_____

Are you in good health? Yes No

Are you under a physician's care for any reason? Yes No

If yes, please explain:

_____

_____

Are you currently using ANY pills, medications, herbal, homeopathic or natural remedies, or any illicit drugs? Yes No

If yes, please list type and dosage, if needed use back of form:

_____

_____

*********

Do you use ANY tobacco products? Yes No

Have you used or use E-cigarettes, e.g. vaping? Yes No

Have you used or use a hookah? Yes No

Have you used or use medical marijuana? Yes No

If yes to any previous 4 questions please describe use:

_____

*********

Do you have any learning or speech disabilities? Yes No

If yes, please explain: _____

_____

FOR PATIENTS UNDER 18 YEARS OF AGE

Current height: _____ Current weight: _____

Updated height: _____ Updated weight: _____

FEMALES ONLY

Are you or do you think you're pregnant? Yes No

If yes, how far along are you? _____

Are you taking any type of birth control? Yes No

If yes, what type? _____

If you're currently age 16 or younger:

What age was onset of menses? _____

MY SIGNATURE BELOW INDICATES THAT I HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Signature: _____
(Parent, Legal Guardian, or Adult Patient only)

Date 1: _____ Date 2: _____