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

MEDICAL HISTORY

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

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

Effective 01 SEP 2025: Texas S.B. 1188 mandates we MUST ask the following:

Biological Sex at Birth (circle one) M F Any diagnosed sexual development disorders? (circle one) Yes No

If yes, please explain: _____

Note: Changes are only allowed for clerical error or a verified disorder of sexual development. Changes require medical documentation.

Please **CIRCLE** the appropriate answers.

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

Arthritis (any type)	Yes	No
Artificial Heart Valves or Joints	Yes	No
Asthma or any Breathing Disorders	Yes	No
Blood Disorders / Transfusions	Yes	No
Cancer / Tumors / Chemotherapy	Yes	No
Chicken Pox / Small Pox	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 / Thyroid Disorders	Yes	No
Measles / Mumps	Yes	No
Osteoporosis / any bone disorders	Yes	No
Radiation Treatment	Yes	No
Rheumatic / Scarlet Fever	Yes	No
Stroke	Yes	No
Tuberculosis / Whooping Cough	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 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:

_____

_____

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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 medical marijuana? Yes No

If yes to any previous questions, please describe use:

_____

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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: _____