



CENTRAL INDIANA ORTHODONTICS INC.

PETER L. CHAPMAN, D.D.S., M.S.D.

www.embrace.com

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL HISTORY

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Please check "yes" or "no" if patient has any history of the following:

Table with 4 columns of YES/NO checkboxes for various medical conditions including Rheumatic Fever, Heart Disease, Asthma, Diabetes, etc.

OTHER INFORMATION

Please explain any answers of "yes" to the above questions (include additional sheet of paper if needed):

\_\_\_\_\_  
\_\_\_\_\_

List all drugs now taken and reason (include additional sheet of paper if needed):

\_\_\_\_\_  
\_\_\_\_\_

List all hospitalizations with dates (include additional sheet of paper if needed):

\_\_\_\_\_  
\_\_\_\_\_

Signature of Custodial Parent/Guardian/Patient Relationship to Patient Date

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## PREMEDICATION ASSESSMENT

Certain medical conditions require antibiotic premedication for involved dental and orthodontic procedures. Such conditions may include:

Artificial Heart Valves	Severe Congenital Heart Disease
Previous Bacterial Endocarditis	Surgical Shunts
Rheumatic Heart Disease	Artificial Joints

YES                      NO

Do you have any medical conditions that require premedication?                                           

If yes, which condition do you have? \_\_\_\_\_

If yes, which medication do you take? \_\_\_\_\_

What is the dosage and when do you take it? \_\_\_\_\_

## LATEX ALLERGY ASSESSMENT

Due to the increasing incidence of latex allergies and the possible associated problems, we would like to assess your possible sensitivity. To help in this evaluation, please answer the following health related questions.

### WE DO NOT USE LATEX GLOVES; HOWEVER, SOME SUPPLIES MAY INCLUDE LATEX MATERIALS

YES                      NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a confirmed latex allergy?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Does any other family member living in the same household have a confirmed latex allergy? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do your lips swell after blowing up a balloon?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have allergies to bananas, kiwis, chestnuts, or avocados?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had multiple surgeries?  |

If you have a known latex allergy, or at some point should develop a latex allergy, please do the following:

- Inform our office of the allergy so that your chart may be amended.
- Try to schedule your appointments during the first part of the day when any airborne allergy particles are at the lowest levels.

Your cooperation is greatly appreciated, and if you should have any questions, please do not hesitate to ask.

## TUBERCULOSIS RISK ASSESSMENT

Due to the increasing incidence of infectious Tuberculosis (TB) and the associated health risk to others, Government regulations now require that all patients entering a health care facility be screened for exposure to Tuberculosis.

To help in this evaluation, please answer the following health related questions:.

YES                      NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have active Tuberculosis (TB)?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Does any other family member living in the same household have active TB? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been vaccinated against TB?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a positive reaction to a TB skin test?                  |

Have you recently had any of the following signs and symptoms of TB infection?:

YES                      NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough lasting 3 weeks or longer? |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood?                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss (not by diet)?                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever?                                      |