HULSE
ORTHODONTICS

American Association of Orthodontists

invisalign

Health History

Are you presently under the care of a physician? ☐Yes ☐No **If yes, for what conditions:**_____

Name of Physician: _____ **Phone: ( )** _____

In the last 5 years, have you ever been:

Hospitalized	Yes	No
Had a serious illness	Yes	No
Had a major operation	Yes	No

Please explain all Yes answers:

_____

_____

_____

Have you ever had, or do you presently have any of the following conditions?

Heart Surgery, Heart Disease, or Heart Attack	Yes	No	Liver Disease/Jaundice	Yes	No
Angina Pectoris/Chest pain	Yes	No	Ulcer	Yes	No
High/Low Blood Pressure	Yes	No	AIDS or HIV Positive	Yes	No
Heart Murmur	Yes	No	Hepatitis A, B, or C	Yes	No
Rheumatic Fever/Rheumatic Heart Disease	Yes	No	Blood Transfusion	Yes	No
Congenital Heart Lesions/Mitral Valve Prolapse	Yes	No	Drug Addiction/Alcoholism	Yes	No
Artificial Heart Valve	Yes	No	Use of Tobacco Products	Yes	No
Heart Pacemaker	Yes	No	Hemophilia or Excessive Bleeding	Yes	No
Artificial Joint/Prosthesis	Yes	No	Use of Fen-Phen, Redux of diet pills	Yes	No
Stroke	Yes	No	Use of Coumadin or Blood Thinners	Yes	No
Kidney Disease	Yes	No	Organ Transplant	Yes	No
Cancer or Tumors	Yes	No	Mental Retardation	Yes	No
Radiation Treatment of the Head or Neck	Yes	No	Psychiatric Treatment	Yes	No
Lung Disease/Tuberculosis	Yes	No	Autism	Yes	No
Diabetes	Yes	No	ADHD	Yes	No
Thyroid Disease	Yes	No	Allergies/Hay Fever	Yes	No
Eating Disorder	Yes	No	Asthma	Yes	No
Arthritis	Yes	No	Sinus Trouble	Yes	No
Bisphosphonate Treatment	Yes	No	Seizures/Epilepsy	Yes	No

Please explain all yes answers above:_____

_____

Have you ever had an allergic or unusual reaction to any of the following?

Latex Materials	Yes	No	
Penicillin	Yes	No	
Erythromycin or Other Antibiotics	Yes	No	
Sulfa Drugs	Yes	No	
Any Other Medication or Drugs	Yes	No	If yes, which Ones?_____

Please list any medications (over the counter or prescription) that you are now taking:_____

_____

If you have ever had any serious complications involving dental treatment, please explain:_____

_____

Over

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