

MEDICAL INFORMATION

Patient's Physician: _____

Do you have a history of or are you being treated for any of the following?

ADD/ADHD	AIDS	Allergies	Anemia	Anxiety	Arthritis		
Asthma	Autism Spectrum	Bleeding	Cancer	COVID-19	Diabetes		
Down's Syndrome	Emotional Disorder	Emphysema	Epilepsy	Eye Problems	Fainting		
Heart	Hepatitis	High Blood Pressure	HIV	Jaundice	Learning/ Behaviourial Disorder		
Lung Disease	Nervous Disorder	Sinus Pressure	Sleep Apnea	Stomach Problems	Stroke		
Thyroid	Tuberculosis	Others	None of the above				
						Y	N

Is general health good?

Are you taking any medications?

Do you have any allergic reactions?

Do you have a latex allergy?

Have you ever had an injury, surgery, or x-ray therapy on the head or jaws?

Any artificial joints, heart valves, pacemaker, or prosthetics?

WOMEN ONLY: Are you pregnant?

If you answered YES to any of the above, please comment below:

I authorize Dr. Karim/Blundell Orthodontics team to carry out an examination (including orthodontic photos, digital photographs, digital xrays and 3D scan) on my dependent/myself. I understand that if I would like to have these records transferred there is a fee.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

SIGNATURE (Please sign/type your name)

Date