



YOUR NAME: _____
 Dentist's Name: _____
 Date of last visit to the dentist? _____
 Physician's Name: _____
 Date of last visit to the physician? _____

Today's Date: _____
 Dentist's Phone #: _____
 Physician's Phone #: _____

MEDICAL History

Please tell us if you have had any of the following by checking the appropriate box(es):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eating Disorders
(Anorexia/Bulimia) | <input type="checkbox"/> Congenital Heart Lesion |
| <input type="checkbox"/> Major Accidents | <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Anemia / Blood Problems | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Rheumatoid or Arthritic Conditions | <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Endocrine or Thyroid Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Frequent Colds/Sore Throat |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Ear, Nose, or Throat Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tire Easily | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Cancers, Tumors, Growths | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Radiation Treatment or Chemotherapy | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Ulcer / Colitis | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Cardiovascular Problems | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vision Disorders | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Fever Blisters |
| | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Pregnant _____ months |
| | <input type="checkbox"/> Speech Disorders | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Osteoporosis |
| | | <input type="checkbox"/> Artificial Heart Valve(s) | |

Please list any ALLERGIES: _____
 Please list any other MEDICAL CONDITIONS not mentioned above: _____
 Please list all MEDICATIONS you are currently taking:
 (Include the dose and frequency) _____

DENTAL History

Please tell us if you have had any of the following by checking the appropriate boxes:

- | | Y | N | | Y | N |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Permanent or "extra" teeth removed? | <input type="checkbox"/> | <input type="checkbox"/> | Nail Biting Habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenitally missing teeth? | <input type="checkbox"/> | <input type="checkbox"/> | Play a musical instrument? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Injuries to the teeth, face, or jaws? | <input type="checkbox"/> | <input type="checkbox"/> | Clench or grind the teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding gums, bad taste, or mouth odor? | <input type="checkbox"/> | <input type="checkbox"/> | Pain or soreness in the muscles of the face? | <input type="checkbox"/> | <input type="checkbox"/> |
| Been treated for periodontal disease? | <input type="checkbox"/> | <input type="checkbox"/> | Been treated for "TMD" / "TMJ"? | <input type="checkbox"/> | <input type="checkbox"/> |
| Food traps between the teeth? | <input type="checkbox"/> | <input type="checkbox"/> | Loose or broken dental fillings? | <input type="checkbox"/> | <input type="checkbox"/> |
| Thumb / Finger Sucking Habit? Until what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Wisdom tooth problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Tongue Thrust Swallowing Habit? | <input type="checkbox"/> | <input type="checkbox"/> | Any relative with a similar bite? | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech Problems? | <input type="checkbox"/> | <input type="checkbox"/> | Prior orthodontic evaluation / treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Mouth breathing habit / snoring? | <input type="checkbox"/> | <input type="checkbox"/> | Ever had an unpleasant dental experience? | <input type="checkbox"/> | <input type="checkbox"/> |

Why are you interested in orthodontic treatment? _____
 How often do you brush? _____ How often do you floss? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes later to this history record or medical / dental status, I will so inform this practice.

Patient's (Parent's/Guardian's) Signature

Date