

Date of last physical examination \_\_\_\_\_ Physician \_\_\_\_\_  
List any medications taken in the past 6 months \_\_\_\_\_  
List any allergies or drug sensitivities \_\_\_\_\_

For the following questions, please circle Yes or No. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation. Do you have or have you ever had:

- |   |   |
|---|---|
| Yes No Birth defects or hereditary problems?                        | Yes No Have you ever had Periodontal (gum) treatment?   |
| Yes No Bone fractures, any major accidents?                         | Yes No Thumb, finger, sucking habit? Until age _____  |
| Yes No Rheumatoid or arthritic conditions?                          | Yes No Abnormal swallowing habit (tongue thrusting)?  |
| Yes No Diabetes?  | Yes No Mouth breathing habit, snoring, difficulty breathing?  |
| Yes No Cancer or been treated for a tumor?                          | Yes No Tooth grinding, jaw clenching, clicking, locking?  |
| Yes No Polio, mononucleosis, tuberculosis, pneumonia?               | Yes No Do you experience any pain or soreness in the muscles of your face, or around your ears?   |
| Yes No Hepatitis, jaundice or liver problem?                        | Yes No Have you ever been treated for "TMJ" problems?   |
| Yes No AIDS or HIV positive?  | Yes No History of extra or missing teeth?   |
| Yes No Sexually transmitted disease?                                | Yes No Have any permanent teeth been removed?   |
| Yes No Fainting, seizures, epilepsy or neurologic disease?          | Yes No Have you ever had prior orthodontic treatment or retainers?  |
| Yes No Mental health or behavioral problems?                        | Yes No Aware/concerned about under or over developed jaw?   |
| Yes No Vision, hearing, tasting or speech difficulties?             | Yes No Any relative with similar tooth or jaw relationships?  |
| Yes No Loss of weight recently, poor appetite?                      | Yes No Have you had any trouble associated with any previous dental treatment?  |
| Yes No Excessive bleeding, anemia or bleeding disorder?             |   |
| Yes No High or low blood pressure?                                  | Female Patient:   |
| Yes No Chest pain, shortness of breath?                             | Yes No Are you pregnant?  |
| Yes No Cardiovascular problem (heart trouble, rheumatic heart)?     | Yes No Are you anticipating becoming pregnant?  |
| Yes No Frequent headaches, colds or sore throat?                    |   |
| Yes No Any history of speech problems?                              | What is your primary concern – Why are you here? _____  |
| Yes No Hayfever, asthma, sinus trouble, hives?                      | _____   |
| Yes No Tonsil or adenoid conditions?                                | Date of most recent dental examination _____  |
| Yes No Hospitalized? For _____                                      |   |
| Yes No Being treated by another health care professional? For _____ | I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. |
| Yes No Chipped or otherwise injured permanent teeth?                |   |
| Yes No Jaw fractures, cysts, mouth infections?                      | _____   |
| Yes No Periodontal disease "gum problems"?                          | Signature of patient (or parent if minor) _____ Date _____  |