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 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.

Yes No Birth defects or hereditary problems?

Yes No Bone fractures, any major accidents?

Yes No Rheumatoid or arthritic conditions?

Yes No History of Osteoporosis?

Yes No Diabetes – please specify Type 1 or 2

Yes No History of cancer or treatment for tumor?

Yes No Polio, mononucleosis, tuberculosis, pneumonia?

Yes No Hepatitis, jaundice or liver problem?

Yes No AIDS or HIV positive?

Yes No Latex Allergy?

Yes No Fainting, seizures, epilepsy or neurologic disease?

Yes No Mental health or behavioral problems?

Yes No Vision, hearing, tasting or speech difficulties?

Yes No Do you get "cold sores"?

Yes No Excessive bleeding, anemia or bleeding disorder?

Yes No High or low blood pressure?

Yes No Chest pain, shortness of breath?

Yes No Cardiovascular problem (heart trouble, rheumatic fever)?

Yes No Frequent headaches, colds or sore throat?

Yes No Any history of speech problems?

Yes No Hayfever, asthma, sinus trouble, hives?

Yes No Tonsil or adenoid conditions?

Yes No Hospitalized? For _____

Yes No Being treated by another health care professional?
For _____

Yes No Chipped or otherwise injured permanent teeth?

Yes No Jaw fractures, cysts, mouth infections?

Yes No Periodontal "gum problems"?

Yes No Have you ever had periodontal treatment, or "deep cleanings

Yes No Thumb, finger, sucking habit? Until age _____

Yes No Abnormal swallowing habit (tongue thrusting)?

Yes No Mouth breathing habit, snoring, difficulty breathing?

Yes No Tooth grinding, jaw clenching, clicking, locking?

Yes No Do you experience any pain or soreness in the muscles of your face, or around your ears?

Yes No Have you ever been treated for "TMJ" problems?

Yes No History of extra or missing teeth?

Yes No Have any permanent teeth been removed?

Yes No Have you ever had orthodontic treatment or retainers?

Yes No Have you ever had Periodontal (gum) treatment?

Yes No Aware/concerned about under or over developed jaw?

Yes No Any relative with similar tooth or jaw relationships?

Yes No Have you had any serious trouble associated with any previous dental treatment?

Female Patient:
Yes No Are you pregnant?

Yes No Are you anticipating becoming pregnant?

What is your primary concern – Why are you here?_____

_____

Date of most recent dental examination _____

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.

_____
Signature of patient or parent if minor Date