MEDICAL HISTORY

Patient's Name_____ Date of Birth_____

Physician's Name and Address_____
Date of last physical examination_____

YES NO (If Yes, please list)

___ ___ Are you currently under treatment for a physical or mental problem?
___ ___ Has there been any change in your general health or weight during the past yr?
___ ___ Are you taking any drugs or medications (including contraceptives or dietary supplements)?
If Yes, please list: _____
___ ___ Have you ever taken Redux/Fenphen, Fosamax, Didronel, Boniva, Actonel, Skelid, or Zometa?
___ ___ Are you allergic to any drugs (including aspirin, penicillin, or codeine)?
If Yes, please list:_____
___ ___ Have you ever had a serious illness or major surgery?
___ ___ Have you ever had a serious accident involving head injuries?
___ ___ Fainting spells, loss of consciousness, seizure, or stroke?
___ ___ Emotional problems or psychiatric care, alcoholism or drug addiction?
___ ___ Frequent headaches or migraines?
___ ___ Glaucoma or other eye disorder?
___ ___ Sinus trouble, tonsillitis, sore throat, or ear infections?
___ ___ Allergies, asthma, or hay fever?
___ ___ Thyroid or endocrine problems?
___ ___ Arthritis or rheumatism?
___ ___ Rheumatic fever/rheumatic heart disease or other valve disorders?
___ ___ Congenital heart defects, mitral valve prolapse, or heart murmur?
___ ___ Cardiovascular disease (heart attack, high/low blood pressure, pacemaker)?
___ ___ Blood disorder, leukemia, anemia, or bleeding problem?
___ ___ HIV, AIDS or other chronic infection?
___ ___ Respiratory disease, pneumonia, tuberculosis, shortness of breath?
___ ___ Diabetes?
___ ___ Liver disease, hepatitis, or jaundice?
___ ___ Kidney disease?
___ ___ Ulcers, stomach, intestinal or bowel problems?
___ ___ Venereal disease, herpes, or other sexually transmitted disease?
___ ___ Surgery, radiation or chemotherapy for a tumor?
___ ___ Physical handicap or learning disability?
___ ___ History of osteoporosis?
___ ___ Prosthetic joints or hip replacement?
___ ___ Birth defects or hereditary problems?
___ ___ Have you reached puberty?
___ ___ Are you pregnant?
___ ___ Do you smoke, chew, use snuff or other forms of tobacco?
___ ___ Do you habitually use controlled substances?

Please describe any other disease, condition, problem, or injury, and current or planned medical treatment or other information the doctor should be aware of:

_____

DENTAL HISTORY

Dentist's Name and Address_____
Date of last dental examination_____

Name and Address of Dental Specialists_____

What concerns you about your teeth?_____
Who suggested that you might need orthodontic treatment?_____
Have you had a previous orthodontic consultation or treatment?_____
Do you think that any of your work or leisure activities affect your teeth or jaws?_____

YES NO (If Yes, please list)

___ ___ Do you brush regularly?
___ ___ Do you floss regularly?
___ ___ Have you ever had any problems with previous dental treatment?
___ ___ Are you allergic to any local anesthetics?
___ ___ Are you allergic to latex?
___ ___ Are you allergic to nickel?
___ ___ Do you have a thumb/finger sucking or lip/nail biting habit?
___ ___ Do you frequently breathe through your mouth?
___ ___ Do you snore at night?

___ ___ Periodontal (gum) surgery or treatment?
___ ___ Temporomandibular joint (TMJ) disorder or treatment?
___ ___ Clicking, soreness, or locking when the mouth is opened?
___ ___ Grinding, clenching of the teeth, or soreness of the jaws upon awakening?
___ ___ Oral surgery or radiation treatment of the jaws, mouth, lips or face?
___ ___ Teeth extracted or missing?
___ ___ Problems with bleeding or healing after surgery?
___ ___ Injuries to the face, mouth, teeth or lips?
___ ___ Frequent canker sores or cold sores?
___ ___ Sensitivity of the teeth to heat, cold, or sweets?
___ ___ Speech therapy?

Please describe any other disease, condition, problem, or injury, and current or planned dental treatment or other information the doctor should be aware of:

_____

I have read the above questions and understand them. I will not hold the orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the orthodontist of any changes in my (or my child's) medical or dental health.

_____ _____
Signature Date

_____ _____
Signature of Parent/Guardian Date