HEALTH HISTORY for _____

MEDICAL HISTORY

Patient's Physician _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y N Abnormal bleeding
Y N Allergies to any drugs
Y N Allergy to latex
Y N Allergy to metals or plastics
Y N Any hospital stays
Y N Any operations or surgery
Y N Asthma or breathing disorder
Y N Cancer, leukemia, lymphoma
Y N Congenital heart defect
Y N Convulsions, seizures or epilepsy
Y N Diabetes
Y N Emotional problems
Y N Handicaps or learning disabilities
Y N Hearing impairment
Y N Heart murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV or AIDS
Y N Kidney or Liver problems
Y N Psychological or psychiatric problems
Y N Rheumatic or scarlet fever
Y N Tuberculosis

PLEASE DISCUSS ALL YES ANSWERS:

Describe your current physical / mental health:
Good Fair Poor

Please list all drugs that you are currently taking:

FEMALE PATIENTS ONLY
Is there any possibility that you are currently pregnant? Y N

DENTAL HISTORY

Patient's Dentist _____

Have there ever been any injuries to the jaws, mouth, chin or teeth? Y N
Has your jaw ever locked in an open or closed position? Y N
Do you ever have any pain, clicking, popping or tenderness in the jaw joints (TMJ)? Y N
Do you get frequent or severe headaches? Y N
Have you ever been evaluated for or had orthodontic treatment before? Y N
Have you ever been told that you have gum problems, bone loss or been advised to see a periodontist? Y N
Do you use dental floss every day? Y N
Have you ever been advised to take antibiotics prior to receiving dental treatment? Y N

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING HABITS OR PROBLEMS?

Y N Clenching or grinding the teeth
Y N Tooth pain or sensitivity
Y N Bleeding or receding gums
Y N Clicking, pain or popping of jaw joints
Y N Speech problems
Y N Thumb or finger sucking
Y N Tongue thrust
Y N Frequently chapped lips
Y N Chewing on pen caps or pencils

What are the main concerns that you would like orthodontic treatment to accomplish?

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature of patient Date

Reviewed by _____ Date _____
Staff

Doctor's Comments: