

PATIENT DENTAL / MEDICAL HISTORY

Date of last dental exam _____ Date of last dental x-rays _____

Check if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |
| <input type="checkbox"/> Breathing through mouth | <input type="checkbox"/> Suck thumb or fingers | <input type="checkbox"/> Teased about teeth |
| <input type="checkbox"/> Speech problems | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Surgery to repair cleft lip/palate |

- Have you had a previous orthodontic consultation? YES NO
- Would patient mind wearing braces? YES NO
- Would patient mind wearing headgear? YES NO
- Is patient concerned about their appearance? YES NO
- Has patient ever experienced TMJ/Joint problems YES NO
- Have any other family member wore braces before? YES NO Whom? _____
- Has a dentist ever placed a retainer or space maintainer YES NO
- Have any primary/permanent teeth been removed by extraction YES NO
- Is patient adopted? YES NO Does he/she know? _____

How often do you floss? _____ How often do you brush? _____

Does patient have any other dental problems not mentioned above? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? YES NO, If yes, describe _____

Is patient currently under physician's care? YES NO, If yes, what for? _____

Is patient currently taking any medication? YES NO, If yes, what? _____

Does patient have a chronic problem with: Heart Kidney Liver Lung

(Women) Are you pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

Has patient ever been diagnosed or treated for any of the following?

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Adenoids removed |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Endocrine | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Tuberculosis |

Any Allergies to: Latex Penicillin Sulfa Aspirin Other _____

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

Signature of parent or guardian _____ Date _____

I hereby give consent to display orthodontic photographs in this office

Signature of parent or guardian _____ Date _____