Dental and Medical History

Patient's Name _____

Physician _____ Date of Last Visit _____

Address _____ Phone _____

General Dentist _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? If yes: _____

Yes No Are you allergic to any medication? If yes: _____

Yes No Do you have a history of a major illness? If yes: _____

Yes No Have you had any operations? If yes: _____

Yes No Have you ever been involved in a serious accident? If yes: _____

Yes No Have you ever smoked or chewed tobacco? If yes: _____

Yes No Have seen a physician in the last 12 months? If yes: _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia	Anemia
Dizziness	Herpes	Prolonged Bleeding	Arthritis	Epilepsy
High Blood Pressure	Radiation/Chemotherapy	Asthma or Hayfever	Gastrointestinal disorders	HIV / Aids
Rheumatic Fever	Bone disorders	Heart problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous disorders	Mumps	Tumor or Cancer
Scarlet Fever	Whooping Cough	Chicken Pox	Measles	Fainting
Problem Chewing	Problem Swallowing			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

What is the chief orthodontic concern?

Yes No Are you presently in any dental/jaw pain?

Yes No Has patient ever experienced any unfavorable reaction to dentistry?

Yes No Have there been lost or chipped any teeth?

Yes No Have there been any injuries to face, mouth, or teeth?

Yes No Is mouth sensitive to temperature? Where?

Yes No Is mouth sensitive to pressure? Where?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Have you ever seen an orthodontist? If yes, who and when?

Yes No What is your attitude toward receiving orthodontic treatment?

Yes No Has anyone in your family received orthodontic treatment?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping?

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?

Yes No Do you have "tension" headaches?

Yes No Have you ever experienced chronic ringing in your ears?

Yes No Are you aware that some appointments will be during work/school hours?

Additional Child Information

Yes No Does the patient need extra help with instructions?

Yes No Height of parents? Mom_____ Dad_____

Yes No Is the patient sensitive or self–conscious about his/her teeth?

Female Patients

Yes No Are you pregnant?

Yes No Has menstruation started?

Signature_____ Date_____