MEDICAL & DENTAL HISTORY

Is the patient in good health? ☐ yes ☐ no Reason ____
Any major or unusual illnesses? ☐ yes ☐ no Explain____
Currently under physician's care? ☐ yes ☐ no Reason____
Currently taking medication? ☐ yes ☐ no List____

Allergies? Asprin__________Nickel__________Latex__________Other____________________________________
Drug sensitivity? Codeine__________Penicillin__________Erythromycin__________Other_________________________

Please Check Yes or No If The Patient Has or Had Any Of The Following:

Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Heart Disease or Murmur	☐	☐	Frequent Colds
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Tonsillitis
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Mononucleosis
☐	☐	Hepatitis	☐	☐	Endocrine Problems	☐	☐	Tonsils removed Age___
☐	☐	AIDS or HIV positive	☐	☐	Bone Disorders	☐	☐	Adenoids Removed
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes or STD	☐	☐	Mouth breathing
☐	☐	Malignancies, Tumors or Cancer	☐	☐	Emotional Stress			

Notes: ____
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Yes	No	
☐	☐	Has the patient had any severe head or face injuries? Explain____
☐	☐	Has the patient had a history of thumb sucking or finger sucking? Stopped? ____
☐	☐	Does the patient play any musical (wind) instrument?
☐	☐	Has the patient consulted an orthodontist previously? Date__________________Doctor_______________________________
☐	☐	Has the patient had any previous orthodontic treatment? Explain____

Please Check Yes Or No For The Following Questions:

Yes	No		Yes	No		Yes	No	
☐	☐	Clenching Teeth	☐	☐	High Decay Rate	☐	☐	Jaw Joint Popping/Clicking
☐	☐	Grinding Teeth	☐	☐	Headaches (more than normal)	☐	☐	Ringing in the Ears
☐	☐	Muscular Soreness (neck &head area)	☐	☐	Jaw Joint Soreness	☐	☐	Tongue Thrust
☐	☐	Snoring Loudly	☐	☐	Mouth Breather	☐	☐	Speech Problem/Speech Therapy
☐	☐	Hard Blow to Chin						

Notes:____
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Emergency information

Name of nearest relative not living with you?____
Complete Address____
Phone___________________________________**Relationship**_____________________________________

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 it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services as needed during diagnosis and treatment.

Signature:____**Date**_________________________