Patient Name:_____ Date:_____

Medical History:

Physician:_____ Phone:_____ Date of Last Exam:_____

Have You Ever Had Any Of The Following? (Please circle yes or no)

Heart Attack/Stroke	**Yes**	**No**	Psychiatric/Learning Problems	**Yes**	**No**
High/Low Blood Pressure	**Yes**	**No**	Epilepsy/Seizures/Fainting Spells	**Yes**	**No**
Diabetes	**Yes**	**No**	Heart Murmur/Heart Disease	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**	HIV+/Aids	**Yes**	**No**
Hemophilia/Abnormal Bleeding	**Yes**	**No**	Heart Surgery/Pacemaker	**Yes**	**No**
Cancer/Chemotherapy/Radiation	**Yes**	**No**	Mitral Valve Prolapse	**Yes**	**No**
Kidney Problems	**Yes**	**No**	Artificial Bones/Joints	**Yes**	**No**
Asthma	**Yes**	**No**	Sinus/Breathing Problems	**Yes**	**No**
Adenoids/Tonsils Removed	**Yes**	**No**	Hepatitis	**Yes**	**No**
Tuberculosis	**Yes**	**No**	Arthritis	**Yes**	**No**
VD (Syphilis, Gonorrhea)	**Yes**	**No**	Fibromyalgia	**Yes**	**No**
Major Operations	**Yes**	**No**	Pain, Pressure or Tightness in Chest	**Yes**	**No**

List any other medical conditions:_____
_____

Are You Now:

Pregnant	**Yes**	**No**	Using Anticoagulants	**Yes**	**No**
On a Prescribed drug	**Yes**	**No**	Using Dilantin or Equivalent	**Yes**	**No**
Using Thyroid Drugs	**Yes**	**No**	Using Hormones (incl. birth control)	**Yes**	**No**
Taking Bisphoshonates (Fosamax, Boniva, Actonel)	**Yes**	**No**	Other Osteoporosis Medications	**Yes**	**No**

List any other medical conditions:_____
_____

Are You Now Taking Or Using Medicines For:

Diabetes (pills or shots)	**Yes**	**No**	Blood (liver, iron pills)	**Yes**	**No**
Nerves (tranquillizers/relaxants)	**Yes**	**No**	Stomach Trouble	**Yes**	**No**
Sleeping	**Yes**	**No**	Headaches	**Yes**	**No**
Heart/Blood Pressure	**Yes**	**No**	Allergies	**Yes**	**No**

Are You Aware Of Any Allergies*:*

Aspirin/Codeine	**Yes**	**No**	Penicillin/Tetracycline/Erythromycin	**Yes**	**No**
Sulfa Drugs	**Yes**	**No**	Other Antibiotics _____	**Yes**	**No**
Dental Anesthetics(ex: Novacaine)	**Yes**	**No**	Latex/Rubber Gloves	**Yes**	**No**
Metal/Nickel Allergies	**Yes**	**No**	Other _____	**Yes**	**No**

Do You Notice Any Of The Following:

Ringing in the Ears	**Yes**	**No**	Pain in Teeth	**Yes**	**No**
Neck Pain	**Yes**	**No**	Face Pain	**Yes**	**No**
Back Pain	**Yes**	**No**	Jaw Pain	**Yes**	**No**
Headaches	**Yes**	**No**	Grinding of Teeth	**Yes**	**No**
Dizziness	**Yes**	**No**	Popping/Clicking of Jaw Joint	**Yes**	**No**

Dental History:

What is the main reason for seeking orthodontic treatment?_____
_____

Have you had orthodontic treatment? If so, by whom? _____	**Yes**	**No**
Do you have missing permanent teeth? If so, list _____	**Yes**	**No**
Do you premedicate before your dental appointment?	**Yes**	**No**
Do you have difficulty swallowing?	**Yes**	**No**
Do your gums bleed when you brush your teeth?	**Yes**	**No**
Have you ever been told you have “gum disease” or periodontitis?	**Yes**	**No**
Have you ever had professional instructions on dental home care?	**Yes**	**No**
Is any part of your mouth sensitive to temperature or pressure?	**Yes**	**No**
Does food catch between your teeth?	**Yes**	**No**
Are you dissatisfied with your teeth and their appearance?	**Yes**	**No**
Are you currently experiencing any pain?	**Yes**	**No**
Have other family members had treatment in our office?	**Yes**	**No**
Have you ever been in an accident? If Yes, Explain_____	**Yes**	**No**
Have you ever had an injury to your mouth/teeth/chin? If Yes, Explain_____	**Yes**	**No**
Has your jaw joint ever locked or felt like it was sticking? If Yes, Explain_____	**Yes**	**No**

I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. In addition, I will notify the doctor of any change in my (or my child’s) health history.

_____
Parent/Guardian Signature Date

_____
Dr. Signature Date

Reviewed Medical History:

_____
Patient/Guardian Signature Date Dr. Signature

_____
Patient/Guardian Signature Date Dr. Signature

_____
Patient/Guardian Signature Date Dr. Signature

_____
Patient/Guardian Signature Date Dr. Signature

_____
Patient/Guardian Signature Date Dr. Signature