Medical and Dental History

Patient's Dentist_____ Last Dental Visit _____
Do You Need A Referral To A Dentist? _____
What Concerns Would You Like Orthodontics To Accomplish? _____
Indicate The Patient's Feelings Towards Orthodontic Treatment _____
Has an Orthodontist Been Previously Consulted?_____
Are Antibiotics Necessary For Teeth Cleaning? _____
Is There Any Dental Work That Needs To Be Completed Prior To Orthodontic Treatment?_____
Physician_____ Last Physical Exam _____
Is The Patient Under The Care Of A Physician At This Time? Please Explain_____
List Any Medications Being Taken At This Time _____
List Any Drugs/Things That The Patient Is Allergic To Or Has A Reaction To _____
Has The Patient Ever Had Any Of The Following Medical Problems?

Abnormal Bleeding	Yes	No	Aids/HIV+	Yes	No	Diabetes	Yes	No
Plastic/Metal Allergy	Yes	No	Heart Problems	Yes	No	Asthma	Yes	No
Latex Allergy	Yes	No	Cancer or Tumor	Yes	No	Hepatitis	Yes	No
Epilepsy/Convulsions	Yes	No	Fainting or Dizziness	Yes	No	Anemia	Yes	No
Thyroid Problems	Yes	No	Pregnant Now	Yes	No	Tuberculosis	Yes	No
Kidney/Liver Problems	Yes	No	Hemophilia	Yes	No	Disabilities	Yes	No
Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Finger/Thumb Sucking	Yes	No	Cavities Now	Yes	No	Mouth Breathing	Yes	No
Tooth/Jaw Trauma	Yes	No	Smoke/Chew Tobacco	Yes	No	Headaches	Yes	No
Lip/Tongue/Nail Biting	Yes	No	Missing Permanent Teeth	Yes	No	Tongue Thrust	Yes	No
Artificial Joint/ Implant	Yes	No	Hay Fever/Allergies	Yes	No	Popping/Jaw Pain	Yes	No
Extensive X-Rays	Yes	No	Radiation Treatment	Yes	No	Rheumatic Fever	Yes	No
Cancer	Yes	No	Snoring	Yes	No	Arthritis	Yes	No
Corticosteroid/Steroid Use	Yes	No	Hearing Problems	Yes	No	Pacifier, Age	Yes	No
Tonsil/Adenoid Problems	Yes	No	Clenching Or Grinding	Yes	No	Extra Teeth	Yes	No

Please Explain Any Medical Or Dental Problem That You Have Had _____
_____
Do You Have Any Disease Or Medical Or Dental Condition That Is Not Mentioned Above? _____

AFFIRMATION

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

_____
Signature Patient/Parent/Guardian Date