

MEDICAL HISTORY

Do you have a personal physician? Y N
Physician's Name: _____
Phone #: _____ Date of last visit: _____
Your current physical health is: Good Fair Poor
Are you currently under the care of a physician: Y N
If yes, please explain: _____

Are you taking any prescription/over-the-counter drugs? Y N
If yes, please list each one: _____

Have you ever had any of the following diseases or medical problems?

| | | | |
|---------------------------|---|---------------------------|---|
| Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Surgery/Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N | Hemophilia/Abnormal | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Bones/Joints | <input type="checkbox"/> Y <input type="checkbox"/> N | Bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Artificial Valve | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | High/Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N | HIV+/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer/Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N | Hospitalized (any reason) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N | Psychiatric Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Drug/Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N | Radiation Therapy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic/Scarlet Fe | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N | Shingles | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Epilepsy/Seizures | <input type="checkbox"/> Y <input type="checkbox"/> N | Sinus Problems | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Fever Blisters/Cold Sores | <input type="checkbox"/> Y <input type="checkbox"/> N | Ulcer/Colitis | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Attack/Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N | Venereal Disease (STD) | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N | | |

Please list any serious medical condition(s) that you have ever had _____

Please discuss any other concerns: _____

Signature (Parent/Guardian if minor): _____ Date: _____

Updates (dates/initial): _____

Reviewed: _____ Date: _____

Are you allergic to any of the following?:

| | | | |
|------------------------|---|--------------|---|
| Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N | Latex | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Any metals or plastics | <input type="checkbox"/> Y <input type="checkbox"/> N | Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N | Tetracycline | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | Other | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N | | |

Please list any other drugs/materials you are allergic to: _____

For Women: Are you taking birth control pills? Y N
Are you pregnant? Y N
If yes, Week #: _____
Are you nursing? Y N

DENTAL HISTORY

Do you currently have a general dentist? Y N
How long has it been since your last dental check-up? _____
(Months)

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

Have you ever been evaluated for orthodontic treatment? Y N

Have you ever had a difficult problem associated with any previous dental work? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you ever had an injury to your: Mouth? Teeth? Chin?

Do you have any speech problems? Y N

If yes, please explain: _____

Do you generally breathe through your mouth? Awake? Y N

Asleep? Y N

Do you have any missing, extra, or impacted permanent teeth? Y N