

MEDICAL HISTORY

1. Please check if patient has or had any problems with the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Metal Allergy | <input type="checkbox"/> Gagging |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Earaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Endocrine (hormone) problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Women: Are you pregnant? |

2. Do you have any allergies or drug sensitivities? Yes No
If yes, to what? _____

3. Have you had rheumatic fever, congenital heart lesions, or damaged artificial heart valves? Yes No
If yes, what? _____

4. Do you have a heart murmur? Yes No

5. Do you take antibiotic premedication when you see a dentist? Yes No
If yes, what kind _____

6. Is there any condition affecting the patient's health other than those mentioned? Yes No
If yes, list _____

7. Do you take any medications for osteoporosis such as Fosamax, Boniva or Actonel? Yes No
If yes, list _____

DENTAL HISTORY

8. Please check if the patient has or had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> Clenching/grinding teeth | <input type="checkbox"/> Missing or Extra teeth | <input type="checkbox"/> Periodontal (gum) disease |
| <input type="checkbox"/> Jaw Joint problems | <input type="checkbox"/> Thumb or Finger sucking | <input type="checkbox"/> Tongue Thrust/Speech problems |

9. Does the patient have more than normal headaches or earaches? Yes No

10. Has the patient received previous orthodontic treatment? Yes No

11. Has anyone in your family had orthodontic treatment? Yes No Whom? _____

12. Please list sibling's names and ages _____

13. Would the patient be willing to wear braces if necessary to correct the problem? _____

14. Is there any reason why treatment should not be started immediately? _____

15. What is the primary reason for seeing an orthodontist? _____

EMERGENCY INFORMATION

Name of nearest relative not living with you. _____ Relationship _____

Complete Address _____ Phone # _____

I understand that it is my responsibility to keep this medical history updated throughout treatment.
I acknowledge that the above information is true and accurate.

Signature

Date