MEDICAL HISTORY

Please check yes or no if the patent has ever had any of the following:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Arthritis	☐	☐	Tonsillectomy	☐	☐
Heart Disease	☐	☐	Bone Disorder	☐	☐	Ear/Nose Surgery	☐	☐
Heart Murmur	☐	☐	Skin Disease	☐	☐	Facial Surgery	☐	☐
Lung Disease	☐	☐	Endocrine Disease	☐	☐	Jaw Surgery	☐	☐
Asthma	☐	☐	Diabetes	☐	☐	Severe Headaches	☐	☐
Ulcers	☐	☐	HIV Positive	☐	☐	Sinus Problems	☐	☐
G-I Disease	☐	☐	Venereal Disease	☐	☐	Hay Fever	☐	☐
Liver Disease	☐	☐	Eye Disease	☐	☐	Allergies	☐	☐
Hepatitis	☐	☐	Cancer	☐	☐	Counselling	☐	☐
Kidney Disease	☐	☐	Epilepsy	☐	☐	Drug Dependence	☐	☐
Bladder Disorder	☐	☐	Depression	☐	☐	Other_____		
Muscle Disease	☐	☐	Back/Neck Injury	☐	☐	_____		

Please Explain Any "Yes" Answers _____

_____

List Any Medications Now Being Taken _____

_____

List Any Drug Allergies _____

List All Hospitalizations/Surgeries and Dates _____

_____

Pregnant Now? Yes ☐ No ☐

DENTAL HISTORY

	Yes	No		Yes	No		Yes	No
Facial Injury	☐	☐	Crowns/Bridges	☐	☐	Nail Biting	☐	☐
Teeth Injury	☐	☐	Denture Partial	☐	☐	Smoking	☐	☐
Cleft Lip/Palate	☐	☐	Wisdom Teeth Out	☐	☐	Tobacco Chewing	☐	☐
Other Anomaly	☐	☐	Other Teeth Out	☐	☐	Grind/Clench	☐	☐
Missing Teeth	☐	☐	Mouth Breathing	☐	☐	Jaw Joint Click	☐	☐
Extra Teeth	☐	☐	Thumb/Finger Habit	☐	☐	Jaw Joint Pain	☐	☐
Gum Disease	☐	☐	Tongue Thrust	☐	☐	Jaw Joint Lock	☐	☐
Root Canal Work	☐	☐	Speech Problem	☐	☐	Snoring	☐	☐

Please Explain Any "Yes" Answers _____

_____

Last Dental Visit Date _____

Has an orthodontist been consulted previously? Yes ☐ No ☐

Describe any previous orthodontic treatment _____

_____

Any family members who have had orthodontics? Yes ☐ No ☐ Who?_____

Apprehensive about orthodontics? Yes ☐ No ☐ Extremely ☐

Are any musical instruments played? _____

What sports are played? _____

_____ _____

Patient/parent/guardian signature Date