

CONFIDENTIAL MEDICAL/DENTAL HISTORY

PATIENT NAME: _____ **DATE:** _____

1. Are you in good health? Y N

2. Has there been a change in your medical history in the past year? Y N

If yes, please explain

3. Have you had a serious illness, operation or hospitalization in the past 5 years? Y N

If yes, please explain

4. Are you under the care of a physician? Y N

If so, name and phone number

5. Please list any medications you are taking at this time:

6. Please list any known allergies:

PLEASE CHECK "Y" FOR YES OR "N" FOR NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

High Blood Pressure Y N

Low Blood Pressure Y N

Heart Disease Y N

Pneumonia Y N

AIDS/HIV Positive Y N

Rheumatic Fever Y N

Lung Disease Y N

Artificial Joints Y N

Heart Murmur Y N

Persistent cough	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Cough blood	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Mitral Valve Prolapse	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Diabetes	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Tuberculosis	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Cardiac Pacemaker	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Hepatitis	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Tobacco Habit	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Shortness of breath	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Anemia/blood disease	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Cancer	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Venereal Disease	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Fainting/Seizures	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Chemotherapy	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Stroke	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Headaches	Y	<input type="checkbox"/>	N	<input type="checkbox"/>
Psychiatric Care	Y	<input type="checkbox"/>	N	<input type="checkbox"/>

9. Have you ever had any problems associated with previous dental treatment Y N
 If yes, please explain:

10. Do you have any other medical conditions we should be aware Y N
 If yes, please explain:

11. Are you a smoker? Y N
 If yes, amount<

12. **WOMEN:** Are you pregnant? Y N

If yes, how many months?

Are you nursing? Y N

DENTAL HISTORY

A. Have you been receiving regular dental care? Y N

Please explain<

B. Have you been told you have periodontal (gum) disease? Y N

Please explain<

C. Are you aware of any existing dental problems? Y N

If so, please describe:

ORTHODONTIC SECTION

Please describe the orthodontic problem as you see it<""

Patient's height:""" Weight:""" Grade in school:

Does/did any other family member have orthodontic treatment? YES NO
If so, who?

Do you have any of the following oral habits?

Lip biting or sucking	YES	NO	Tongue thrusting	YES	NO
Thumb or finger sucking	YES	NO	Teeth grinding	YES	NO
Nail or pencil biting	YES	NO	Constant mouth breathing	YES	NO

Any other oral habits?

AUTHORIZATION

The information contained on this form is correct to the best of my knowledge. I will not hold this dental office or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize this dental office to perform diagnostic and therapeutic procedures as may be necessary for proper Orthodontic care.

Signature _____ Date _____
(Parent/Guardian)