## CONFIDENTIAL MEDICAL/DENTAL HISTORY

**PATIENT NAME:** **DATE:**

**MEDICAL HISTORY**

| | | |
|---|---|---|
| 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. Please provide name(s) and phone number(s) of current physicians:

5. Please list any medications you take at this time:

6. Please list any known allergies, including latex or nickel:

7. Please check “Y” for yes or “N” for no if you have or have 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 Prostheses | Y | N |
| Heart Murmur | Y | N | Breathing Difficulties | Y | N |
| Sinus Problems | Y | N | Persistent Cough | Y | N |
| Cough Blood | Y | N | Mitral Valve Prolapse | Y | N |
| Diabetes | Y | N | Tuberculosis | Y | N |
| Cardiac Pacemaker | Y | N | Hepatitis | Y | N |
| Shortness of Breath | Y | N | Anemia/Blood Disease | Y | N |
| Cancer | Y | N | Chemotherapy | Y | N |
| Fainting/Seizures | Y | N | Venereal Disease | Y | N |
| Tobacco Habit | Y | N | Stroke | Y | N |
| Headaches | Y | N | Psychiatric Care | Y | N |

8. Do you have any other medical conditions we should be aware of? Y N

9. Are you a smoker? Y N If yes, amount:

10. WOMEN: Are you pregnant? Y N

**<u>DENTAL HISTORY</u>**

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

Date of Last Cleaning/Exam:

2. Have you ever had any problems associated with previous dental treatment? Y N

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

If yes, please explain:

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

If so, please describe:

5. Have you ever experienced trauma or injury to the teeth or face? Y N

If yes, please describe in detail:

**<u>ORTHODONTIC SECTION</u> (TO BE COMLETED BY THE PATIENT OR GUARDIAN)**

1. Please describe the orthodontic problem as you see it:

2. Patient's height: 3. Patient's weight: 4. Grade in school:

5. Females – Onset of first menstrual period (relates to growth):

6. Does/did any other family member have orthodontic treatment? Y N

7. Do you have any of the following oral habits?

| | | | | | |
|---|---|---|---|---|---|
| Lip biting or sucking | Y | N | Tongue thrusting | Y | N |
| Thumb or finger sucking | Y | N | Teeth grinding | Y | N |
| Nail or pencil biting | Y | N | Constant mouth breathing | Y | N |

8. 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 ________________________________