

PLEASE CHECK THE FOLLOWING AS THEY APPLY

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma or Allergies | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Adopted | <input type="checkbox"/> Hepatitis/Liver Disease |
| <input type="checkbox"/> Animal Allergies | <input type="checkbox"/> AIDS, HIV+ | <input type="checkbox"/> Night Grinding of teeth | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ | | |

List any medication now being taken. Give reason: _____

List any drug sensitivities: _____

Dental History

- Have there been any injuries to the face, mouth, or teeth? _____ Yes No D/K
- Have you ever had gum disease? _____ Yes No D/K
- Do you get "Gum Boils", frequent canker sores or cold sores? _____ Yes No D/K
- Do you take any forms of fluoride? _____ Yes No D/K
- Have you been informed of any missing or extra permanent teeth? _____ Yes No D/K
- Any serious trouble associated with any previous dental treatment? _____ Yes No D/K
- Has an orthodontist been consulted previously? If so, by whom? _____ Yes No D/K
- Have you ever had orthodontic treatment? If so, by whom _____ Yes No D/K
- Has anyone in your family had orthodontic treatment? _____ Yes No D/K
- Do you have an unusual amount of stress in your life? _____ Yes No D/K
- Do you or have you ever smoked or chewed tobacco? _____ Yes No D/K
- Is there any family medical conditions, we should know about? _____ Yes No D/K

Please list any family members treated here _____

Reason for seeking orthodontic treatment (what Problem do you wish to have corrected?) _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Patient Signature

<p>For Office Use Only: <input type="checkbox"/> ID Verification</p>
