



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 sold 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

**For Office Use Only:**  
 ID Verification