

Medical History

Have you ever had any of the following diseases or medical problems?

- Y N Abnormal Bleeding/Hemophilia
Y N HIV/AIDS
Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints/Valves
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Fever Blisters/Herpes
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hepatitis
Y N High Blood Pressure
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/ Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical conditions that you have ever had \_\_\_\_\_

Do you have a personal Physician? \_\_\_yes \_\_\_no
Physician's Name \_\_\_\_\_
Phone# \_\_\_\_\_ Date of last visit \_\_\_/\_\_\_/\_\_\_
Your current physical health is: \_\_\_good\_\_\_fair\_\_\_poor
Are you currently under the care of a physician?
\_\_\_yes \_\_\_no
Please explain \_\_\_\_\_
Are you taking any prescription/over-the-counter drugs?
\_\_\_yes \_\_\_no

Please list each one:

\_\_\_\_\_

Do you smoke or use tobacco in any other form?

\_\_\_yes \_\_\_no

Have you had any metal rods, pins or implants?

\_\_\_yes \_\_\_no

For Women: Are you pregnant? \_\_\_yes \_\_\_no

Are you allergic to any of the following?

- Y N Aspirin Y N Jewelry/ Metals
Y N Codeine Y N Latex
Y N Dental Anesthetics Y N Penicillin
Y N Erythromycin Y N Tetracycline

Please list any other drugs/materials that you are allergic to \_\_\_\_\_

Are you taking Bisphosphonates (circle one): Fosamax, Boniva, Zometa, Reclast, Actonel, Didronel or other \_\_\_\_\_

Dental History

What are the main concerns that you would like orthodontics to address? \_\_\_\_\_

Have you ever had or been evaluated for orthodontic treatment? \_\_\_yes \_\_\_no

Have you ever had a serious/difficult problem associated with any previous dental work? \_\_\_yes \_\_\_no

Do you now or have you ever experienced pain/discomfort in your jaw joint(TMJ/TMD)? \_\_\_yes \_\_\_no

Your dental health is: \_\_\_good \_\_\_fair \_\_\_poor

Do you still have wisdom teeth? \_\_\_yes \_\_\_no

Have you ever had an injury to your mouth, chin or teeth? \_\_\_yes \_\_\_no

Do you have any speech problems? \_\_\_yes \_\_\_no

Do you generally breathe through your mouth? \_\_\_yes \_\_\_no

Do you have any missing or extra permanent teeth? \_\_\_yes \_\_\_no

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

Signature \_\_\_\_\_

Date \_\_\_\_\_

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_

Date \_\_\_\_\_