Patient's Name _____ Age _____ Date _____

MEDICAL HISTORY

1. Physician _____ City _____

2. Is patient being treated by the physician now for anything?..... Yes No

   If so, explain _____

3. Is patient taking any medication(s)?..... Yes No

   Names _____

   For what condition(s)? _____

4. Is patient allergic to any medications?..... Yes No

   Name(s) _____

5. Has patient had tonsils removed?..... Yes No
   Has patient had adenoids removed?..... Yes No

6. List patient's surgeries, serious illnesses or diseases, past or present: _____

   _____

   _____

7. Circle any of the following patient has had at past or present:

1. Heart Failure
2. Heart Disease
3. Heart Attack
4. Heart Surgery
5. Irregular Heart Beat
6. Angina Pectoris
7. High Blood Pressure
8. Low Blood Pressure
9. Heart Murmur
10. Artificial Heart Valve
11. Mitral Valve Prolapse
12. Heart Pacemaker
13. Rheumatic Fever
14. Congenital Heart Lesions
15. Scarlet Fever
16. Stroke
17. Hemophilia
18. Taking Blood Thinners
19. Bleeding Tendency
20. Anemia
21. Artificial Joint
22. Sickle Cell Disease
23. HIV Positive
24. AIDS
25. Chest Pain
26. Shortness of Breath
27. Asthma
28. Bruise Easily
29. Emphysema
30. Tobacco Smoker – Chewer
31. Chronic Bronchitis
32. Tuberculosis (TB)
33. Hay Fever
34. Lung Trouble
35. Allergies or Hives
36. Diabetes
37. Thyroid Disease
38. Cancer
39. Radiation Therapy
40. Cobalt Treatment
41. Chemotherapy
42. Arthritis
43. Rheumatism
44. Tonsillitis
45. Sinus Trouble
46. Cortisone Medication
47. Epilepsy/Convulsions
48. Drug Abuse
49. Alcohol Abuse
50. Hepatitis A (Infectious)
51. Hepatitis B (Serum)
52. Ulcers
53. Kidney/Bladder Trouble
54. Blood Trasnfusion
55. Liver Disease
56. Yellow Jaundice
57. Problems Healing
58. Venereal Disease
59. Lyme Disease
60. Parkinson's Disease
61. Glaucoma
62. Contact Lenses
63. Fainting
64. Dizziness
65. Frequent Headaches
66. Injury to Face or Jaw
67. Nervousness
68. Psychiatric Treatment
69. Cold Sores
70. Emotional Problems
71. Snapping or Cracking of Jaw

ON REVERSE SIDE OF THIS FORM PLEASE LIST NUMBERS OF ANY CIRCLED ITEM(S)
AND GIVE A DETAILED EXPLANATION OF EACH ITEM

8. Female Patients:
   Are you pregnant now?..... Yes No
   Are you taking a birth control pill?..... Yes No
   Do you anticipate becoming pregnant in the near future?..... Yes No

9. Does patient have any special problems not listed above?..... Yes No

   Explain _____

DENTAL HISTORY

Name of Dentist _____ City _____

1. Date of last visit to the dentist _____
2. Has patient ever received an injury to teeth (falls, blows, chips, etc.)?..... Yes No

   Date and nature of injuries _____
3. Does the patient play a musical instrument?..... Yes No

   What? _____
4. Is patient concerned about appearance of his/her teeth?..... Yes No
5. Has patient had or does he/she presently have any of the following habits?

   __ thumb- or finger-sucking __ grinding of teeth at night

   __ lip-biting __ mouth-breathing
6. Can patient chew adequately with the natural teeth?..... Yes No
7. Do patient's gums bleed?..... Yes No
8. Are the patient's teeth sensitive to cold, heat, or sweets?..... Yes No
9. How often does patient brush his/her teeth per day? _____
10. Does patient have difficulty in opening or closing his/her mouth?..... Yes No
11. Has patient had previous orthodontic consultation or treatment?..... Yes No
12. Has their been any orthodontic treatment for any other member of the family?

    __ Mother __ Father __ Brother(s) __ Sister(s)
13. Were the results satisfactory?..... Yes No

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEEDING ASNWERS ARE TRUE AND CORRECT. IF PATIENT EVER HAS ANY CHANGE IN HIS/HER HEALTH, OR IF MEDICATIONS CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

_____ _____

Signature of Patient, Parent or Guardian Date

_____

Relationship of Patient to Signee

Date Checked: _____ Signature: _____

_____ _____

_____ _____

_____ _____