



- PATIENT'S DENTAL HISTORY -

Yes No

\_\_\_ \_\_\_ Has the patient had any severe head or face injuries? Explain: \_\_\_\_\_

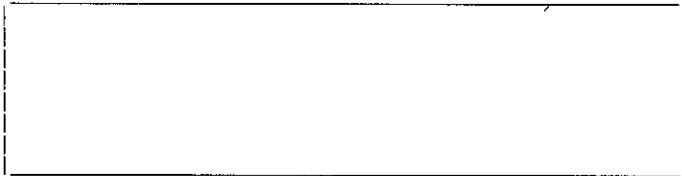
\_\_\_ \_\_\_ Has the patient had a history of thumb sucking or finger sucking? \_\_\_ Stopped? \_\_\_ When? \_\_\_\_\_

\_\_\_ \_\_\_ Does the patient play any musical (wind) instruments? What? \_\_\_\_\_

\_\_\_ \_\_\_ Has the patient consulted an orthodontist previously?

\_\_\_ \_\_\_ Has the patient had any previous orthodontic treatment?

\_\_\_ \_\_\_ Did either parent have orthodontic treatment?



Please check if there is a history of:

\_\_\_ Clenching Teeth

\_\_\_ Jaw Joint Soreness

\_\_\_ Ringing in the Ears

\_\_\_ Grinding Teeth

\_\_\_ Jaw Joint Clicking

\_\_\_ Restricted Jaw Opening

\_\_\_ Muscular Soreness around Head and Neck

\_\_\_ Jaw Joint Popping

\_\_\_ Jaw Locking Open or Closed

\_\_\_ Headaches (more than normal)

- PATIENT'S MEDICAL HISTORY -

Is the patient in good health? \_\_\_ yes \_\_\_ no Explain: \_\_\_\_\_

Any major or unusual illnesses? \_\_\_ yes \_\_\_ no Explain: \_\_\_\_\_

Currently being treated by physician? \_\_\_ yes \_\_\_ no Reason: \_\_\_\_\_

Currently taking medication? \_\_\_ yes \_\_\_ no Reason: \_\_\_\_\_

Allergies? \_\_\_ yes \_\_\_ no List: \_\_\_\_\_

Drug sensitivity? \_\_\_ yes \_\_\_ no List: \_\_\_\_\_

Does the patient have or has the patient had any of the following:

Yes No Yes No Yes No

\_\_\_ \_\_\_ Anemia \_\_\_ \_\_\_ Heart Problems \_\_\_ \_\_\_ Frequent Colds or Flu

\_\_\_ \_\_\_ Blood Disease \_\_\_ \_\_\_ Tuberculosis \_\_\_ \_\_\_ Tonsillitis

\_\_\_ \_\_\_ Prolonged Bleeding \_\_\_ \_\_\_ Diabetes \_\_\_ \_\_\_ Adenoiditis

\_\_\_ \_\_\_ Jaundice \_\_\_ \_\_\_ Endocrine Problems \_\_\_ \_\_\_ Tonsils Removed: Age: \_\_\_\_\_

\_\_\_ \_\_\_ Rheumatic Fever \_\_\_ \_\_\_ Bone/Joint Disorders \_\_\_ \_\_\_ Adenoids Removed: Age: \_\_\_\_\_

\_\_\_ \_\_\_ Scarlet Fever \_\_\_ \_\_\_ Epilepsy \_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ Hepatitis \_\_\_ \_\_\_ Herpes \_\_\_ \_\_\_ Mouthbreathing: While awake? \_\_\_\_\_

\_\_\_ \_\_\_ Glaucoma \_\_\_ \_\_\_ While asleep? \_\_\_\_\_

\_\_\_ \_\_\_ Is the Patient in a high risk group for AIDS? \_\_\_ \_\_\_ Has the patient been found to be HIV positive?

\_\_\_ \_\_\_ Is the patient now, or ever been, addicted to drugs? \_\_\_ \_\_\_ Does the patient have AIDS?

If there are any YES answers, please explain \_\_\_\_\_

Is there any other information that may be helpful? \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*THIS OFFICE WILL NOT BE RESPONSIBLE FOR PROBLEMS ARISING FROM UNDISCLOSED OR INCORRECT INFORMATION.\*\*

THANK YOU !!

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_ Updated (date & initials) \_\_\_\_\_