



## MEDICAL HISTORY

Do you have a personal physician? Y N

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: Y N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Are you taking any prescription/over-the-counter drugs? Y N

If yes, please list each one: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Anemia Y N Heart Surgery/Pacemaker Y N

Arthritis Y N Hemophilia/Abnormal Y N

Artificial Bones/Joints Y N Bleeding Y N

Artificial Valves Y N Hepatitis Y N

Asthma Y N High/Low Blood Pressure Y N

Blood Transfusion Y N HIV+/AIDS Y N

Cancer/Chemotherapy Y N Hospitalized (any reason) Y N

Congenital Heart Defect Y N Kidney Problems Y N

Diabetes Y N Mitral Valve Prolapse Y N

Difficulty Breathing Y N Psychiatric Treatment Y N

Drug/Alcohol Abuse Y N Radiation Therapy Y N

Emphysema Y N Rheumatic/Scarlet Fever Y N

Glaucoma Y N Shingles Y N

Epilepsy/Seizures Y N Sinus Problems Y N

Fainting Spells Y N Tuberculosis (TB) Y N

Fever Blisters/Cold Sores Y N Ulcer/Colitis Y N

Heart Attack/Stroke Y N Venereal Disease (STD) Y N

Heart Murmur Y N

Please list any serious medical condition(s) that you have

ever had: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please discuss any other concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature (Parent/Guardian if minor): \_\_\_\_\_ Date: \_\_\_\_\_

Updates (dates/initial): \_\_\_\_\_

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

Are you allergic to any of the following?:

Aspirin Y N Latex Y N

Any metals or plastics Y N Penicillin Y N

Codeine Y N Tetracycline Y N

Dental Anesthetics Y N Other Y N

Erythromycin Y N

Please list any other drugs/materials you are allergic to:

\_\_\_\_\_

*For Women:* Are you taking birth control pills? Y N

Are you pregnant? Y N

If yes, Week #: \_\_\_\_\_

Are you nursing? Y N

## DENTAL HISTORY

Do you currently have a general dentist? Y N

How long has it been since your last dental check-up? \_\_\_\_\_  
(Months)

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

\_\_\_\_\_

Have you ever been evaluated for orthodontic treatment? Y N

Have you ever had a difficult problem associated with any previous dental work? Y N

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you ever had an injury to your: Mouth? Teeth? Chin?

Do you have any speech problems? Y N

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you generally breathe through your mouth? Awake? Y N

Asleep? Y N

Do you have any missing, extra, or impacted permanent teeth?

Y N