# MEDICAL HISTORY

Physician Date of Last Visit

Address Phone

Please circle Yes or No (If Yes, please fill in details)

|  |  |  |
| --- | --- | --- |
| Yes | No | Are you taking any medication?  |
| Yes | No | Are you allergic to any medication?  |
| Yes | No | Do you have a history of a major illness?  |
| Yes | No | Have you had any operations?  |
| Yes | No | Have you ever been involved in a serious accident?  |
| Yes | No | Have seen a physician in the last 12 months? Why?  |

Circle any of the medical conditions below that you have had or currently have.

|  |  |  |  |
| --- | --- | --- | --- |
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of?

# DENTAL HISTORY

General Dentist Date of last visit What concerns you most about your teeth?

|  |  |  |
| --- | --- | --- |
| Yes | No | Are you presently in any dental pain?  |
| Yes | No | Have you ever experienced any unfavorable reaction to dentistry?  |
| Yes | No | Have you ever lost or chipped any teeth?  |
| Yes | No | Have there been any injuries to face, mouth, or teeth?  |
| Yes | No | Is any part of your mouth sensitive to temperature? Where?  |
| Yes | No | Is any part of your mouth sensitive to pressure? Where?  |
| Yes | No | Do your gums bleed when you brush?  |
| Yes | No | Do you have any type of thumb or tongue habit?  |
| Yes | No | Are you a mouth breather?  |
| Yes | No | Have you ever seen an orthodontist? If yes, who and when?  |
| Yes | No | What is your attitude toward receiving orthodontic treatment?  |
| Yes | No | Has anyone in your family received orthodontic treatment?  |
|  |  | How did they feel about the result?  |
| Yes | No | Do your teeth or jaws ever feel uncomfortable when you awake in the morning?  |
| Yes | No | Are you aware of your jaw clicking or popping?  |
| Yes | No | Are you aware of clenching your teeth during the day?  |
| Yes | No | Have you ever been told that you grind your teeth?  |
| Yes | No | Do you have “tension” headaches?  |
| Yes | No | Have you ever experienced chronic ringing in your ears?  |
| Yes | No | If the patient is under age 16, height of parents? Mom Dad\_  |
| Yes | No | Are you aware that some appointments will be during school/work hours?  |
|  |  | Please list some hobbies or interests  |
|  |  | Female Patients only: |
| Yes | No | Are you pregnant?  |
| Yes | No | Has menstruation started?  |

Signature: Date: