



**MEDICAL HISTORY**

**Patient Name:** \_\_\_\_\_

**PLEASE CHECK YES OR NO TO THE FOLLOWING AND GIVE DATE**

	<b>Yes</b>	<b>No</b>	<b>Year</b>		<b>Yes</b>	<b>No</b>	<b>Year</b>		<b>Yes</b>	<b>No</b>	<b>Year</b>
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic / Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seasonal Type Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____											
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disorder/ Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sickle Cell Anemia/Trait	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Speech Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV+ / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____	Surgery/ Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsils Removed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug / Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other \_\_\_\_\_

Please give greater details where necessary \_\_\_\_\_

Drugs or medications taken currently (drug & dosage)? \_\_\_\_\_

Any known drug allergies? Yes  No  Details \_\_\_\_\_

Allergies to latex or metals? Yes  No  Details \_\_\_\_\_

Any birth defects? Yes  No  Details \_\_\_\_\_

Any injuries to the face, mouth, or teeth? Yes  No  Details \_\_\_\_\_

Presently under medical care for anything? Yes  No  Details \_\_\_\_\_

{GIRLS} Has menstruation begun? Yes  No  Date \_\_\_\_\_

**DENTAL HISTORY**

What are your main concerns with regard to your teeth? \_\_\_\_\_

When was your last dental exam/ cleaning? \_\_\_\_\_

Have you ever had periodontal (gum) treatment? Yes  No  Details \_\_\_\_\_

Have you ever had oral surgery? Yes  No  Details \_\_\_\_\_

Are you missing any permanent teeth? Yes  No  Details \_\_\_\_\_

Have you had a previous orthodontic evaluation? Yes  No  Details \_\_\_\_\_

Have you had previous orthodontic treatment? Yes  No  Details \_\_\_\_\_

Do you have a current or past finger or thumb habit? Yes  No  Details \_\_\_\_\_

Do you clench or grind your teeth? Yes  No  Details \_\_\_\_\_

Do you have any clicking or popping of the jaw? Yes  No  Details \_\_\_\_\_

Has your jaw ever locked open or closed? Yes  No  Details \_\_\_\_\_

Ever have pain in your jaw joint or ear? Yes  No  Details \_\_\_\_\_

Ever have difficulty opening or closing your jaw? Yes  No  Details \_\_\_\_\_

**PATIENT / PARENT SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

REVIEWED _____	DATE _____	REVIEWED _____	DATE _____
REVIEWED _____	DATE _____	REVIEWED _____	DATE _____
REVIEWED _____	DATE _____	REVIEWED _____	DATE _____
REVIEWED _____	DATE _____	REVIEWED _____	DATE _____