



MEDICAL HISTORY:

Is the patient in good health? Yes No

Is the patient under a physician's care? Yes No

If yes, please briefly describe: _____

Please list any drugs and/or medications being taken: _____ Give reasons: _____

Please list any allergies or drug sensitivities: _____

Does the patient have a history of any of the following? Diabetes Heart Murmur Epilepsy Thyroid Disease
 Bone Disorder Rheumatic Fever Hepatitis Prolonged Bleeding

Does the patient require antibiotic premedication before dental treatment? Yes No

Have the tonsils/adenoids been removed? Yes No If yes, at what age? _____

DENTAL HISTORY:

Have there ever been any injury to the face, mouth, or teeth? Yes No

If yes, please briefly describe: _____

Has the patient ever sucked a thumb or finger? Yes No

Does the patient have any speech problems? Yes No

Is the patient a mouth breather? Awake Sleeping Yes No

Has the patient ever been informed of any missing or extra teeth? Yes No

Has the patient ever had a previous orthodontic exam? Yes No

Do any relatives have a similar tooth or jaw condition as the patient? Yes No

If yes, please briefly describe: _____

Does the patient have anxiety or require extra time for appointments? Yes No

If yes, please briefly describe: _____

Has any family member been previously treated in this office? Yes No Name: _____

When did the patient last have dental care? _____

Briefly state what you would like to achieve with orthodontic treatment: _____

Please list any sports, hobbies, and/or interests: _____