

Patient's Name _____

Your overall physical and dental health as well as any medications which you take can have an important relationship to the orthodontic treatment you receive. Please answer each of the following questions carefully and completely as related to the patient.

Dental History

Dentist _____ Last dental visit _____

Last dental x-rays _____ Any teeth removed by the dentist? _____

Frequency of brushing? _____ Flossing? _____

Has an orthodontist been consulted before? _____ Any prior orthodontic treatment? _____

Is the water fluoridated? _____ Are any fluoride supplements used? _____

Check any of the following that apply that apply:

- | | |
|--|--|
| <input type="checkbox"/> finger or thumb sucking habit | <input type="checkbox"/> grinds teeth |
| <input type="checkbox"/> nail biting | <input type="checkbox"/> clenches jaws |
| <input type="checkbox"/> chews hard objects (pencils, etc) | <input type="checkbox"/> history of TMJ problems |
| <input type="checkbox"/> lip biting or sucking | |

Medical History

Physician _____ Phone number _____

Previous hospitalizations/surgeries/serious illnesses _____

Is there a history of allergies or adverse reactions to any drugs or medications (e.g. penicillin)? _____

Is there a history of allergy to any other substances (e.g. latex)? _____

Are any medications currently being taken? _____

Check any of the following that have ever applied (past or present):

- | | |
|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> disability |
| <input type="checkbox"/> cancer | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> hemophilia | <input type="checkbox"/> congenital heart defect |
| <input type="checkbox"/> abnormal bleeding | <input type="checkbox"/> heart murmur |
| <input type="checkbox"/> stomach, liver or kidney problems | <input type="checkbox"/> convulsions/epilepsy |
| <input type="checkbox"/> heart disease/heart trouble | <input type="checkbox"/> faintness/dizziness |
| <input type="checkbox"/> prosthetic heart valves | <input type="checkbox"/> tonsils or adenoids removed |

Please explain any existing medical problems: _____

The questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. I understand that it is my responsibility to inform the orthodontic office of any changes in the patient's medical status.

Signature of patient/parent

Date