

MEDICAL HISTORY

Please check any of the following for which the patient has been treated:

- | | | | | | | | | |
|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---------------------------|
| Yes | No | | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, Hay Fever, Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Fainting or Dizzy Spells |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Adenoids Removed Age_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Tonsils Removed Age_____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Colds and/or Flu | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> | Autism |

List any behavioral drugs being taken _____

List any physical or behavioral issues that might prevent sitting for prolonged periods of time _____

List any other serious illnesses or medical problems _____

List any allergies (including those to any drugs or medications) _____

List any drugs or medications now being taken _____

DENTAL HISTORY

- | | Yes | No |
|---|--------------------------|--------------------------|
| Has the patient ever sucked a thumb or finger?
If yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient have any speech problems?
If yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient clench or grind his or her teeth (at night)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does the patient have pain or clicking upon opening or closing the mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the patient had any severe head or face injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have any of the teeth been injured or chipped due to accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been informed of any extra or missing permanent teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any noticeable difficulty in chewing or swallowing food? | <input type="checkbox"/> | <input type="checkbox"/> |
| Would the patient mind wearing braces? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of any tongue thrusting problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| Facial appearance most resembles <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Neither <input type="checkbox"/> Both | | |
| If the patient is female, has she started her monthly period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the patient consulted with another orthodontist? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has the patient had any previous orthodontic treatment?
If yes, explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last dental appointment _____ Were x-rays taken? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware that some appointments will infringe upon school time? | <input type="checkbox"/> | <input type="checkbox"/> |

Parent or Guardian Signature _____