MEDICAL HISTORY

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

Yes	No		Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Convulsions/Epilepsy	☐	☐	Nervous Disorders
☐	☐	Pneumonia	☐	☐	Asthma, Hay Fever, Allergies	☐	☐	Endocrine Problems
☐	☐	Heart Trouble	☐	☐	Anemia	☐	☐	Fainting or Dizzy Spells
☐	☐	Rheumatic Fever	☐	☐	Prolonged Bleeding	☐	☐	Adenoids Removed Age____
☐	☐	Tuberculosis	☐	☐	Bone Disorders	☐	☐	Tonsils Removed Age____
☐	☐	Pregnancy	☐	☐	Frequent Colds and/or Flu	☐	☐	Hepatitis
☐	☐	Depression	☐	☐	ADD/ADHD	☐	☐	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 ____________	☐	☐
Does the patient have any speech problems? .... If yes, explain ____________	☐	☐
Does the patient clench or grind his or her teeth (at night)?	☐	☐
Does the patient have pain or clicking upon opening or closing the mouth?	☐	☐
Has the patient had any severe head or face injuries?	☐	☐
Have any of the teeth been injured or chipped due to accidents?	☐	☐
Have you been informed of any extra or missing permanent teeth?	☐	☐
Is there any noticeable difficulty in chewing or swallowing food?	☐	☐
Would the patient mind wearing braces?	☐	☐
Are you aware of any tongue thrusting problems?	☐	☐
Facial appearance most resembles ☐ Father ☐ Mother ☐ Neither ☐ Both		
If the patient is female, has she started her monthly period?	☐	☐
Has the patient consulted with another orthodontist?	☐	☐
Has the patient had any previous orthodontic treatment? .... If yes, explain ____________	☐	☐
Date of last dental appointment ____________ Were x-rays taken?	☐	☐
Are you aware that some appointments will infringe upon school time?	☐	☐

Parent or Guardian Signature ____________________