MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment: ☐ Yes ☐ No

Specify: ______________________

Date of Last Dental Cleaning ______________________

PRESENT DRUGS OR MEDICATION: ☐ Yes ☐ No

Specify: ______________________

Has patient been under care of a physician during the past two years other than for routine examination? ☐ Yes ☐ No

Birth Defects ☐ Yes ☐ No

Specify: ______________________

The following conditions are of interest to the orthodontist.
Has the Patient ever had:

☐ Yes ☐ No Asthma	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Heart Disease
☐ Yes ☐ No Anemia	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Hearing Disorder
☐ Yes ☐ No Blood Disease	☐ Yes ☐ No Endocrine Problems	☐ Yes ☐ No Head or Face Injury
☐ Yes ☐ No Bone Disorders	☐ Yes ☐ No Emotional Problems	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Aids	☐ Yes ☐ No HIV Infections	

Comments:

Does the patient:

1. Have allergies to: Seasonal grasses __________ Food __________
   Drugs __________ Other __________
2. Snore When Sleeping? ☐ Yes ☐ No
3. Breathe through mouth? Seldom Sometimes Usually Comments__________
4. Have Frequent colds? ☐ Yes ☐ No
5. Have Frequent sore throat or tonsillitis? ☐ Yes ☐ No

Has patient received medical treatment from allergist or ear, nose and throat specialist?

☐ Yes ☐ No if Yes: When __________ By Whom __________

Tonsils removed __________ Adenoids removed __________

Have any teeth been injured due to accidents or blows to the mouth? ☐ Yes ☐ No

Has the patient received or been requested to receive speech correction? ☐ Yes ☐ No

Thumb sucking until age __________ Grinding of teeth __________ ☐ Yes ☐ No

Finger sucking until age __________ Tongue thrusting __________ ☐ Yes ☐ No

Lip-biting or sucking? ☐ Yes ☐ No Other habits ☐ Yes ☐ No

Has the patient had any unusual dental experiences? ☐ Yes ☐ No

Specify: ______________________

Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No

Date: __________ Dr. ______________________

Are there any other medical, dental or surgical problems not covered above? ☐ Yes ☐ No

Do you have pain in the face, neck or shoulders? ☐ Yes ☐ No

Do you have frequent headaches? ☐ Yes ☐ No

Do you have recurring tooth pain or sensitivity? ☐ Yes ☐ No

Do you have ringing, fullness or pain in your ears? ☐ Yes ☐ No

Do you have difficulty opening your mouth or does your jaw get "stuck" or "locked"? ☐ Yes ☐ No

Do your joints make noises upon opening or closure? ☐ Yes ☐ No

Do you have difficulty or pain with chewing, talking or yawning? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have arthritis? ☐ Yes ☐ No

Have you had any previous treatment for your jaw joint (TMJ problem)? If so, when and by whom? ______________________

Signature ______________________ Date __________

Relationship to patient ______________________

-FOR COMPLETION BY THE DOCTOR-

Comments on patient interview concerning medical history: