MEDICAL AND DENTAL HISTORY

Name _____ Age _____ Date of Birth _____

Please describe the reason(s) for seeking orthodontic care (braces). _____

_____

If you are the parent of the patient, do you feel this problem is a concern that is shared by your child? _____

When did you (parent of guardian) first become aware of this orthodontic problem? _____

Who or what first brought the problem to your attention? _____

Do you feel that is it becoming ( ) better, ( ) worse, ( ) neither.

Do you have any idea what may have caused it? _____

Is there any similarity to father, mother, or others in the family?

( ) yes ( ) no In what way? _____

MEDICAL HISTORY

Date of last physical exam: _____ Were any problems brought to your attention? _____

_____

yes no Are you presently under the care of a physician? Name and reason: _____

_____

yes no Are you taking any medications? What? _____

yes no Has a member of your family had diabetes? Who _____

yes no Have you ever had to seek medical or dental treatment to stop bleeding following a cut or tooth extraction?

yes no Are you allergic to any drugs? What? _____

yes no Have you had any operations or serious illnesses? List and give dates: _____

_____

_____

yes no Do you smoke? How much? _____

Please Check Any of the Following Conditions or Diseases Which You May Have Had:

( ) Heart disease
( ) Heart Murmur
( ) High blood pressure
( ) Low blood pressure
( ) Blood disorders
( ) Rheumatic fever
( ) Anemia
( ) Liver disease
( ) Kidney disease
( ) Tuberculosis
( ) Lung disease
( ) Diabetes
( ) Cancer
( ) HIV positive
( ) Sinus trouble
( ) Hepatitis
( ) Nervous or Mental disorder
( ) Hearing difficulties
( ) Speech difficulties
( ) Stomach trouble
( ) Arthritis
( ) Asthma
( ) Joint diseases

DENTAL HISTORY

yes no Do you have frequent bleeding gums after brushing?

yes no Do you bite your finger nails?

yes no Do you frequently clench or grind your teeth when tired, tense, angry or asleep?

yes no Do you chew gum, use lifesavers, mints or Rolaids daily. *(Underline)*

yes no Do you think you would be disturbed if you had to lose your teeth and wear false teeth?

yes no Have you ever had orthodontic treatment? (Braces)

yes no Have you ever had an injury to your teeth, jaws or face?

Explain: _____

yes no Do you have any oral habits such as lip, cheek or tongue biting; finger, thumb, lip or tongue sucking? *(Underline)*

yes no Do you have difficulty breathing or chewing? Explain: _____

Female

yes no Have you been pregnant? How many times?

yes no Have you had a baby that weighed in excess of 9 pounds at birth?

yes no Are you taking birth control pills?

yes no Have you reached puberty and started menstruation (periods)? At what age?