

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Address _____ Phone # _____
What concerns you most about your teeth? _____

Please circle Yes or No (If Yes, please fill in details).

Yes No Have you had previous orthodontic consultation or treatment? When? _____
Yes No Do you have any difficulty chewing or swallowing?
Yes No Have any family members had orthodontic treatment? Who? _____
Yes No Are you aware of any tooth grinding or clenching?
Yes No Do you have pain or clicking of the jaw joint?
Yes No Have you ever had a severe head or jaw injury?
Yes No Do your gums bleed on brushing or flossing?
Yes No Have you had any permanent teeth extracted?
Yes No Do you experience "tension" headaches more than once a week?
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Yes No Are there any other dental/orthodontic problems I should be aware of?

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you ever smoked or chewed tobacco? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Are you pregnant?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Allergies	Nervous Disorders	Tumor or Cancer
Phen-fen (diet drug)		Osteoporosis	

Are there any medical conditions we have not discussed that you feel we should be aware of?

Patient's signature _____ Date _____