

DENTAL HISTORY

General Dentist _____ Date of last visit _____
Address _____ Phone# _____

What is the major concern about the patient's teeth? _____

- Yes No Has the patient had previous orthodontic consultation or treatment? When? _____
Yes No Has the patient been informed of any extra or missing teeth?
Yes No Have any family members had orthodontic treatment? Who? _____
Yes No Does the patient now suck the thumb or fingers?
Yes No Does the patient predominately breath through the mouth or have any type of tongue habit?
Yes No Does the patient have any speech problems?
Yes No Does the patient grind or clench the teeth?
Yes No Does the patient have pain or clicking of the jaw joint?
Yes No Have any teeth been injured due to an accident?
Yes No Has the patient ever had a severe head or jaw injury?
Yes No Does the patient experience "tension" headaches?
Yes No Does the patient need extra help with instructions?
Yes No Does the patient's gums bleed on brushing or flossing?
Yes No Is the patient sensitive or self-conscious about his/her teeth?
Yes No Are there any other dental/orthodontic problems I should be aware of?
Yes No Height of parents? Mom _____ Dad _____
Yes No Are you aware that some appointments will be during school hours?

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone# _____

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

- Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Has the patient had tonsils and/or adenoids removed?
Female Patients only:
Yes No Has menstruation started?
Yes No Is the patient pregnant?

Circle any of the medical conditions below that the patient has had or currently has.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Allergies | Dizziness | Herpes | Prolonged Bleeding |
| Anemia | Emotional Disorders | High Blood Pressure | Radiation/Chemotherapy |
| Arthritis | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Asthma or Hay fever | Heart Problems | Kidney problems | Tuberculosis |
| Bone Disorders | Nervous Disorders | Tumor or Cancer | Epilepsy |

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

Parent's Signature _____ Date _____