PATIENT'S MEDICAL HISTORY

For the following questions mark *yes, no, or don't know/understand (dk/u)*. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocain or Lidocaine)
☐yes ☐no ☐dk/u Aspirin, Ibuprofen (Motrin, Advil)
☐yes ☐no ☐dk/u Penicillin or other antibiotics
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Other substances (specify) ____________
____
☐yes ☐no ☐dk/u Is the patient taking any medications?
Medication Taken for ______________________________

MEDICAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Birth defects or hereditary problems?
☐yes ☐no ☐dk/u Diabetes?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, Jaundice or liver problem?
☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
☐yes ☐no ☐dk/u Heart problems ________________
____
☐yes ☐no ☐dk/u Frequent headaches
☐yes ☐no ☐dk/u Operations/Hospitalizations?
Please Describe:________________
____
☐yes ☐no ☐dk/u Are you Pregnant?
How many weeks? ______________
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe ________________
☐yes ☐no ☐dk/u Being treated by another health care professional? For ______________
____

Are there any other medical conditions that we should be aware of:______________________________

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Any cavities or gum problems that still need treatment?
☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?
☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?
☐yes ☐no ☐dk/u Periodontal "gum problems"?
☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
☐yes ☐no ☐dk/u Thumb, finger, or sucking habit?
Until what age?______________
☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing? Asthma?
☐yes ☐no ☐dk/u Tooth grinding, jaw clenching, clicking or locking?
☐yes ☐no ☐dk/u Any pain in jaw or ringing In the ears?
☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?
When______________________

When was your last Dental Cleaning ______________
and Check up______________________________

I authorize the orthodontist to assess (Patient's Name) ______________________________ for the possibility of orthodontic treatment. I understand that diagnostic procedures may be performed, such as radiographs, photos, and a clinical examination, in order to properly assess and treatment plan orthodontic conditions.

You have the right to accept or reject treatment recommended by your orthodontist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

I certify that I can speak, read, and write English and have read and fully understand this form. To the best of my knowledge all the preceding answers are true and correct.

Date__________

Patient/Guardian Signature______________________ Patient/Guardian Name ________________

Orthodontist Signature______________________ Orthodontist Name ________________

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