Patient's Dentist ______________________ **Physician** ______________________

Reason for your orthodontic examination:

○ Appearance of teeth ○ Crowded teeth ○ Upper teeth "stick out" ○ Mismatched jaws ○ My dentist referred me

○ Seeking a second opinion ○ Other : ______________________

Medical History

Now or in the past has the patient had:

YES	NO	
○	☐	Previous orthodontic treatment?
○	☐	Birth defects or hereditary problems?
○	☐	Autism, Asperger's, or sensory interpretation disorder?
○	☐	Mental health disturbance or depression?
○	☐	Seizures, fainting spells, neurologic problems?
○	☐	Bone fractures or major injuries?
○	☐	History of Osteoporosis?
○	☐	Arthritis or joint problems?
○	☐	Cancer, tumor, radiation treatment or chemotherapy?
○	☐	Diabetes?
○	☐	Endocrine or thyroid problems?
○	☐	Hepatitis, jaundice or other liver problems?
○	☐	Kidney problems?
○	☐	Stomach ulcer, hyperacidity or acid reflux?
○	☐	Frequent headaches or migraines?
○	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
○	☐	Heart defects, heart murmur, rheumatic heart disease?
○	☐	Angina, arteriosclerosis, stroke or heart attack?
○	☐	High or low blood pressure?
○	☐	Skin disorder (other than common acne)?
○	☐	Excessive bleeding or bruising tendency, anemia?
○	☐	AIDS or HIV positive?
○	☐	Sexually transmitted diseases?
○	☐	Polio, mononucleosis, tuberculosis, pneumonia?
○	☐	Eating disorder (anorexia, bulimia)?
○	☐	Intravenous bisphosphonates for bone disorders or cancer? Zometa Aredia Didrone
○	☐	Oral bisphosphonates for bone disorders? Fosamax Actonel Boniva Skelid Didronel
○	☐	Undergoing medical treatment now? ______________________ ______________________

Female:

YES	NO	
○	☐	Is the patient pregnant or anticipate becoming pregnant?

YES	NO	
○	☐	Speech problems or speech therapy?
○	☐	Tongue thrust habit?
○	☐	Tonsil or adenoid condition?
○	☐	Asthma, sinus problems, hayfever?
○	☐	Mouth breathing habit or snoring at night?
○	☐	Difficulty breathing through the nose?
○	☐	Vision or hearing problems?
○	☐	Any sensitive or sore teeth?
○	☐	Any teeth treated with root canals or "nerve removal"?
○	☐	Chipped or injured primary or permanent teeth?
○	☐	Born with extra or missing teeth?
○	☐	Any permanent or extra teeth removed?
○	☐	Teeth causing irritation to their lip, cheek or gums?
○	☐	Any serious trouble from previous dental treatment?
○	☐	Oral habits (sucking finger, chewing pen, etc.)?
○	☐	Tooth grinding or clenching?
○	☐	Soreness in their jaw muscles or face muscles?
○	☐	Clicking or locking in jaw joints?
○	☐	Jaw joint problems such as "TMJ" or "TMD"?
○	☐	Jaw fractures, cysts, infections?
○	☐	Any injuries to the face, head or neck?
○	☐	Gum disease or periodontal problems ("pyorrhea")?
○	☐	Allergies or adverse reactions to any of the following? ○ Latex ○ Metals ○ Acrylics ○ Antibiotics ○ Aspirin or Ibuprofen (Motrin, Advil) ○ Plant pollens ○ Other substances
○	☐	Taking prescriptions or medications? Please List: ______________________ ______________________
○	☐	Is there anything else in the medical history you would like us to know? ______________________ ______________________

I have read the above questions and understand them. I will not hold my orthodontist or any of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in the patient's medical or dental history.

Patient/Parent/guardian signature ______________________ Date ____________