

Medical Information

Patient's Physician: _____

Is patient in good health? Yes No _____

Does patient have any history of major illness? _____

Has patient been treated by a Physician for: (Check where appropriate)

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma
<input type="checkbox"/> Anemia
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Endocrine Problems
<input type="checkbox"/> Bone Disorders | <input type="checkbox"/> A. I. D. S.
<input type="checkbox"/> Heart problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Presently Pregnant
<input type="checkbox"/> Tonsils / Adenoids Removed (age) _____ | <input type="checkbox"/> Liver Problems
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Emotional Problems
<input type="checkbox"/> Epilepsy or Convulsions
<input type="checkbox"/> Prolonged Bleeding
<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Other _____ |
|---|---|---|

Allergies? Including Latex or Metal _____

Is patient taking prescription medications? No___ Yes (please list) _____

If patient is a minor: Has puberty been reached? (Menstruation or voice change) No ___ / Yes If within the last 2 years, when? _____

Is patient adopted? Yes___ / No___

Any other past hospitalizations or surgeries? _____

Dental Information

Name of general dentist: _____ Office # _____

No Yes If Yes, More Information

	No	Yes	
Has patient had a recent dental exam?			
Injuries to mouth or teeth?			
Clicking or pain when opening jaws?			
Has jaw ever locked open or closed?			
Difficulty chewing or eating?			
Teeth grinding or clenching?			
Previous orthodontic treatment? When?			
Has dentist removed primary (baby) teeth?			
Has dentist removed permanent teeth?			
Thumb sucking or finger habits?			
Frequent mouth sores?			
Is patient a mouth breather?			
Has anyone else in the family worn braces?			
High intake of sweets?			
Any traumatic dental experiences?			

School Attending _____ Grade _____

List Sports Played _____

Hobbies/ Interests _____

List Any Instruments Played _____

Siblings/Children _____

Friends or Family that are patients _____

Patient's attitude toward orthodontic treatment? Eager Complacent Not Enthusiastic

We welcome your comments or suggestions? _____

Updates (Date & Initial-for office use) _____

CONFIDENTIAL (for record and pretreatment evaluation)