

MEDICAL HISTORY

Have you ever been treated for ..

	YES	NO		YES	NO	HIV	YES	NO
Diabetes	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
Heart trouble	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	Tonsillitis	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Bone disorders	<input type="radio"/>	<input type="radio"/>	Convulsions	<input type="radio"/>	<input type="radio"/>	Prolonged bleeding	<input type="radio"/>	<input type="radio"/>
Any other medical concerns? _____							<input type="radio"/>	<input type="radio"/>
Do you wear contact lenses? _____							<input type="radio"/>	<input type="radio"/>
Do you have arthritis? _____							<input type="radio"/>	<input type="radio"/>
Have your wisdom teeth been removed? If yes, at what age? _____							<input type="radio"/>	<input type="radio"/>
Are you currently under the care of a physician? If yes, why? _____							<input type="radio"/>	<input type="radio"/>
Are you allergic to any drugs or medications? _____							<input type="radio"/>	<input type="radio"/>
List any drugs or medications now being taken								
_____ why? _____								
_____ why? _____								
_____ why? _____								

DENTAL HISTORY

Have there been any injuries to face, mouth or teeth? _____

Do you play a wind instrument? _____ what kind? _____

Do you have any problems with your speech? _____

Do you breathe predominantly through your mouth? _____

Have you been informed of any missing or extra permanent teeth? _____

Have you had any previous orthodontic examinations? _____

Have you had any periodontal treatment? _____

Do you feel that you need orthodontic treatment? _____

When did you last visit your dentist? _____ Were X-rays taken? _____

Reason for orthodontic examination? _____

TMJ HISTORY

Do you have frequent head or neck aches? _____

Have you had any discomfort or clicking in the jaw-joints near ears? _____

Do you clench or grind your teeth? _____

Do you have pain or ringing in the ears? _____

Has your jaw ever locked or slipped out of place? _____

Do you have any sensitive or sore teeth? _____

Signature _____