



**MEDICAL HISTORY**

Has the patient ever been treated for ..

	YES	NO		YES	NO		YES	NO
Diabetes	<input type="radio"/>	<input type="radio"/>	Hay Fever	<input type="radio"/>	<input type="radio"/>	HIV	<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"/>
						Endocrine-thyroid	<input type="radio"/>	<input type="radio"/>

Any other medical concerns? \_\_\_\_\_

List any drugs or medications now being taken

\_\_\_\_\_ why? \_\_\_\_\_  
 \_\_\_\_\_ why? \_\_\_\_\_  
 \_\_\_\_\_ why? \_\_\_\_\_

Is the patient allergic to any drugs or medications? \_\_\_\_\_

Have tonsils and adenoids been removed? \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

Growth in the past 6 months? \_\_\_\_\_ Has the patient reached puberty? \_\_\_\_\_

Height: Patient \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Patient most resembles  Mother  Father  Both

**DENTAL HISTORY**

Have there been any injuries to the face, mouth or teeth? \_\_\_\_\_

Did the patient ever suck thumb or fingers? \_\_\_\_\_ Until what age? \_\_\_\_\_

Did the patient have any problems with speech? \_\_\_\_\_

Does the patient play a wind musical instrument? \_\_\_\_\_ What kind? \_\_\_\_\_

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

Has the patient had any previous orthodontic examinations? \_\_\_\_\_

Is the patient especially apprehensive towards dental visits? \_\_\_\_\_

Does the patient want orthodontic treatment? \_\_\_\_\_

When did the patient last visit his/her dentist? \_\_\_\_\_ Were X-rays taken? \_\_\_\_\_

Does the patient have any congenital abnormalities? \_\_\_\_\_

**TMJ HISTORY**

Has the patient had any discomfort or clicking in the jaw-joints near ears? \_\_\_\_\_

Does the patient clench or grind his/her teeth? \_\_\_\_\_

Does the patient have frequent head or neck aches? \_\_\_\_\_

Does the patient have pain or ringing in the ears? \_\_\_\_\_

Has the patient's jaw ever locked or slipped out of place? \_\_\_\_\_

Are his/her teeth sore or sensitive? \_\_\_\_\_

This form was completed by: (parent's signature if minor) \_\_\_\_\_  Mom  Dad