



## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Is patient currently under physician's care? Reason: \_\_\_\_\_

Is patient taking any medications? \_\_\_\_\_

Is patient aware of being allergic to or has ever reacted adversely to any medications? \_\_\_\_\_

Please check box if you now have or have had:

- |   |  |
|---|--|
| <input type="checkbox"/> Tonsils or Adenoids removed<br><input type="checkbox"/> AIDS<br><input type="checkbox"/> Allergies/Sinus Trouble<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Artificial heart valves<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bone disorders<br><input type="checkbox"/> Congenital heart lesions<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emotional problems<br><input type="checkbox"/> Endocrine/Thyroid problems<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Faintness/Dizziness | <input type="checkbox"/> Fever blisters<br><input type="checkbox"/> Headaches (frequent)<br><input type="checkbox"/> Heart murmur<br><input type="checkbox"/> Heart trouble<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> HIV positive<br><input type="checkbox"/> Joint swelling<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Psychiatric treatment<br><input type="checkbox"/> Rad/Chemo/Blood therapy<br><input type="checkbox"/> Rheumatic fever<br><input type="checkbox"/> TMJ Problems |
|---|--|

Please check box if answer is YES:

- |  |   |
|--|---|
| <input type="checkbox"/> Is patient pregnant?<br><input type="checkbox"/> Has patient reached puberty?<br><input type="checkbox"/> Thumb, finger, lip sucking? (circle)<br><input type="checkbox"/> Mouth-breathing when awake, asleep? (circle)<br><input type="checkbox"/> Any missing/extra permanent teeth?<br><input type="checkbox"/> Any teeth removed by extraction?<br><input type="checkbox"/> Is there a tongue-thrust problem?<br><input type="checkbox"/> Any speech problems?<br><input type="checkbox"/> Has an orthodontist been consulted previously?<br>Reason: _____<br>_____ | <input type="checkbox"/> Any injuries to face, mouth, teeth? (circle)<br><input type="checkbox"/> Any pain or popping on opening mouth?<br><input type="checkbox"/> Are you aware of an uncomfortable or bad bite?<br><input type="checkbox"/> Do you have any jaw symptoms or headaches upon waking each morning?<br><input type="checkbox"/> Does the patient smoke?<br><input type="checkbox"/> Latex allergy?<br><input type="checkbox"/> History of gum disease or periodontal problems?<br><input type="checkbox"/> Grinding teeth?<br><input type="checkbox"/> Any family members with similar orthodontic problems? |
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Are you aware of any other disease, condition or problem not listed above that we should know about? \_\_\_\_\_

In your own words, describe your orthodontic problem and what you would like orthodontic treatment to accomplish: \_\_\_\_\_

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs and send dentist information regarding diagnostic findings. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

Updates (date and initial) \_\_\_\_\_