



ORTHODONTICS
For Children and Adults

MEDICAL/DENTAL HISTORY

Patient's Name: _____

Dentist's Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Please indicate if the patient has any of the following conditions:

- Yes No Currently under any medical treatment. Please describe _____
- Yes No Pain, clicking, and/or popping noises in the jaw
- Yes No Clenching or grinding of teeth
- Yes No Frequent headaches. How often? _____
- Yes No Ear problems (Aches, ringing, dizziness, fullness)
- Yes No Difficulty breathing through the nose
- Yes No Habits such as nail biting, finger or thumb sucking, lip or cheek biting
- Yes No Speech problems, or undergoing speech therapy
- Yes No Tonsils and/or adenoids removed
- Yes No Has there been any history of: Joint swelling Asthma TB HIV/AIDS Kidney Liver Condition
Epilepsy Rheumatic Fever Thyroid Disorder Other major illnesses _____
- Yes No Bleeding problems _____
- Yes No Fainting or dizzy spells
- Yes No Allergies (Sulfa, Penicillin, Novocain, Latex, etc.) _____
- Yes No Currently taking any medication. Please list: _____
- Yes No Heart condition. Do you pre-medicate? Yes No Cardiologist: _____
- Yes No Sleep apnea
- Yes No Smoke or chew tobacco
- Yes No Any injuries to the teeth. Please describe _____
- Yes No Any permanent teeth extracted
- Yes No Have we treated any other family members? Names: _____
- Yes No Are there any other medical conditions or history that we should know about? Please describe:

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in the medical history or medications, I will inform the doctor at my next appointment without fail.

Responsible Party's Signature: _____ Date: _____

