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# MEDICAL HISTORY

***Now or in the past, have you had?***

___ Y ___ N Birth defects or hereditary problems?
___ Y ___ N Bone fractures, any major accidents?
___ Y ___ N Rheumatiod or thyroid problems?
___ Y ___ N Kidney problems?
___ Y ___ N Diabetes?
___ Y ___ N Cancer, tumor, radiation treatments or chemotherapy?
___ Y ___ N Stomach ulcer or hyperacidity?
___ Y ___ N AIDS or HIV positive?
___ Y ___ N Hepatitis, jaundice or liver problems?
___ Y ___ N Fainting, seizures, epilepsy or neurological problems?
___ Y ___ N Mental health disturbance or depression?
___ Y ___ N Vision, hearing, tasting or speech difficulties?
___ Y ___ N Loss of weight recently, poor appetite?
___ Y ___ N History of eating disorder (anorexia, bulimia)?
___ Y ___ N Excessive bleeding or bruising tendency, anemia or bleeding disorder?
___ Y ___ N High or low blood pressure?
___ Y ___ N Tired easily?
___ Y ___ N Chest pain, shortness of breath/swelling ankles?
___ Y ___ N Cardiovascular problems?_____
___ Y ___ N Skin disorder?
___ Y ___ N Do you have a well balanced diet?
___ Y ___ N Frequent headaches, colds or sore throats?
___ Y ___ N Eye, ear, nose or throat conditions?
___ Y ___ N Hay fever, asthma, sinus trouble or hives?
___ Y ___ N Tonsil or adenoid conditions?
___ Y ___ N Osteoporosis?

***Allergies or reactions to any of the following:***

___ Y ___ N Local anesthetics (Novocaine or lidocaine)
___ Y ___ N Aspirin
___ Y ___ N Ibuprofen (motrin, advil)
___ Y ___ N Penicillin or other antibiotics
___ Y ___ N Sulfa drugs
___ Y ___ N Codeine or other narcotics
___ Y ___ N Metals (jewelry,clothing snaps)
___ Y ___ N Latex (gloves, ballons)
___ Y ___ N Vinyl
___ Y ___ N Acrylic
___ Y ___ N Animals
___ Y ___ N Foods (Specify)_____
___ Y ___ N Other substances (Specify) _____
___ Y ___ N Are you t aking medication, nutrient supplements herbal medications or non-prescription medicine? Please name them below
_____
_____
___ Y ___ N Do you currently have or ever had a substance abuse problem?
___ Y ___ N Do you chew or smoke tobacco?
___ Y ___ N Operations?_____
___ Y ___ N Hospitalizations? _____
___ Y ___ N Other physical problems or symptoms?
_____
___ Y ___ N Being treated by another health care professional?
_____
___ Y ___ N Date of most recent exam_____
Do you have any other medical condition that we should know about?_____

# MEDICAL HISTORY CONTINUED

**WOMAN ONLY**

___ y ___ N Are you pregnant?

___ y ___ N Are you anticipating becoming pregnant?

**FAMILY MEDICAL HISTORY**

Do your parents or siblings have, or have ever had any of the following health problems? Is so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

_____

_____

**DENTAL HISTORY**

Now or in the past, has the patient had:

___ Y ___ N Permanent or extra (Supernumerary) teeth removed?

___ Y ___ N Extra (Supernumerary) or congenitally missing teeth?

___ Y ___ N Chipped/otherwise injured primary (baby) or permanent teeth?

___ Y ___ N Teeth sensitive to hot or cold; teeth throb or ache?

___ Y ___ N Jaw fractures, cysts or mouth infections?

___ Y ___ N "Dead teeth" or root canals treated?

___ Y ___ N Bleeding gums, bad taste or mouth odor?

___ Y ___ N Periodontal "gum problems"?

___ Y ___ N Food impacted between teeth?

___ Y ___ N "Gum boils" frequent canker sores or cold sores?

___ Y ___ N Thumb, finger, or sucking habit? Until what age? _____

___ Y ___ N Abnormal swallowing habit? (Tongue thrusting)?

___ Y ___ N History of speech problems or speech therapy?

___ Y ___ N Mouth breathing habit, snoring or difficulty in breathing?

___ Y ___ N Tooth grinding or jaw clenching?

___ Y ___ N Any pain, clicking, or locking in jaw or ringing in the ears?

___ Y ___ N Any pain or soreness in the muscles of the face or around the ears?

___ Y ___ N Difficulty in chewing or jaw opening?

___ Y ___ N Have you ever been treated for "TMD" or "TMJ"?

___ Y ___ N Aware of loose, broken, missing restorations (Fillings)?

___ Y ___ N Any teeth irritating cheek, lip, tongue, or palate?

___ Y ___ N Concerned about spaced, crooked or protruding teeth?

___ Y ___ N Aware or concerned about under or over developed jaw?

___ Y ___ N Any relative with similar tooth or jaw relationships?

___ Y ___ N Any wisdom tooth problems?

___ Y ___ N Had periodontal (gum) treatment?

___ Y ___ N Had any serious trouble associated with any previous dental treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Signed: _____ Date signed: _____

*(Patient)*

Signed: _____ Date signed: _____

*(Dental staff member)*