Please Answer All Questions
(Circle yes or no and print in blanks where required)

Date _____
Name _____

I. MEDICAL HISTORY

Date of last Medical examination _____ By whom? _____

1. Is the patient in general good health at this time? Yes No
2. Is the patient now or has he/she been under the care of a physician during the past two years (other than routine checks)? Yes No

   Reason: _____

   _____
3. Is the patient receiving any medicine or pills now? Yes No

   If so, list: _____
4. Has the patient ever had any surgery? Yes No

   For what conditions: _____
5. The following diseases are of interest to the Orthodontist. Please check any that the patient has had:

❑ Allergies, list _____	❑ Endocrine problems	❑ Lung disease
❑ Anemia	❑ Epilepsy	❑ Nervous disorders
❑ Asthma	❑ Fainting or dizziness	❑ Prolonged bleeding
❑ Blood disease	❑ Glaucoma	❑ Rheumatic fever
❑ Bone disorders	❑ Heart disease	❑ Rheumatism or arthritis
❑ Cerebral palsy	❑ Hepatitis	❑ Rickets
❑ Colds (frequent)	❑ High or low blood pressure	❑ Sore throat (frequent)
❑ Diabetes	❑ Jaundice.	❑ Stomach or intestinal disease
❑ Ear infection (frequent)	❑ Kidney disease	❑ Tuberculosis
❑ Emotional disorders	❑ Liver disease	❑ Tumors or growths
❑ ADD / ADHD		❑ HIV/AIDS

6. Does the patient have any special conditions not listed above? Yes No

   Explain: _____
7. Is the patient's height and weight normal for his/her age? Yes No

   a. Patient's height _____ Father's Height _____ Mother's Height _____

   b. How many inches has the patient grown in the past year? _____
8. Has the patient reached puberty? Female age at onset of menses? _____ Yes No
9. Has the patient ever had a serious accident involving head injuries? Yes No
10. Has the patient ever had an unusual reaction to any drug such as penicilin or local anesthetic? What? _____ Yes No
11. Has the patient ever experienced any complications to healing? Yes No
12. Has the patient ever had any X-ray treatments (other than diagnostic)? Yes No
13. Have tonsils and/or adenoids been removed? At what age? _____ Yes No
14. Does the patient have a diet high in sweets or snacks? Yes No
15. Evaluate the following as good, fair or poor:

Cooperation _____	General health _____	Toothbrushing _____
Dental flossing _____	Hearing _____	Vision _____

16. Is the patient pregnant? Yes No

(Over)

II. DENTAL HISTORY

Date of last Dental examination _____ By whom? _____ Is work done?_____

Date of last full-mouth X-ray_____ Where?_____

1. Is the patient concerned about the appearance of his/her teeth? Yes No
2. Has orthodontic treatment been suggested in the past? Yes No
3. Who first noticed the need for orthodontic treatment? Circle one:
   Dentist Patient Parent
4. Has the patient had previous orthodontic consultations and/or treatment? Where? _____ Yes No
5. Does the patient have reservations about orthodontic treatment? Yes No
6. Is the patient willing to give maximum cooperation for approximately two years? Yes No
7. Are you aware that some appointments will infringe on school time? Yes No
8. How many times a year has your dentist examined the patient's teeth? _____
9. Has the patient had any serious trouble associated with any previous dental treatment? Yes No
   If so, explain _____
10. Does the patient have any present dental complaints? Yes No
    If so, explain _____
11. Is the patient having any discomfort or pain? Yes No
12. Are there now any unhealed injuries or inflamed areas in or around the patient's mouth? Yes No
13. Does the patient have any problems with sore and/or bleeding gums? Yes No
14. Is any part of the patient's mouth sore to pressure or irritants (cold, sweets, etc.)? Yes No
    If so, locate _____
15. Has the patient ever had a jaw or mouth injury? Explain _____ Yes No
16. Have there ever been any injuries to the patient's teeth? Explain _____ Yes No
17. Has the patient ever had pain in or near the ear? Yes No
18. Has the patient ever had or will be having speech therapy? Yes No
19. Does the patient play a musical instrument? What? _____ Yes No
20. Does the patient have any of the following habits?
    ❑ Thumb or finger-sucking ❑ Nail biting ❑ Tongue thrusting
    ❑ Lip-biting or sucking ❑ Grinding of teeth ❑ Mouth breathing
21. Deciduous (baby) teeth came in: ❑ Early ❑ Average ❑ Late
22. Deciduous (baby) teeth came out: ❑ Early ❑ Average ❑ Late
23. Did any teeth have to be removed by the dentist? Yes No
24. Who does the face (lips and chin) and teeth of the patient most resemble? ❑ Father ❑ Mother ❑ Other
25. How many times a day does the patient brush his/her teeth? _____
26. Does the patient use dental floss? Yes No
27. Has the patient ever been instructed in proper toothbrushing technique? Yes No
28. Is anyone in the extended family congenitally missing teeth? Yes No

Please make any other comments that you feel may be helpful: _____

_____

_____

Person filling out this form _____ Relationship to patient _____