

HEALTH HISTORY

Physician's Name _____ Phone # _____

Is patient currently under physician's care? Reason: _____

Are you taking any medications? _____

Are you aware of being allergic to or have you ever reacted adversely to any medications? _____

Please check box if you now have or have had:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Adenoids removed | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic fever/Scarlet/yellow fever |
| <input type="checkbox"/> Allergies/Sinus Trouble | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear problems | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> TMJ problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Faintness/Dizziness | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bruxing | <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Wound healing problems |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Hemophiliac | <input type="checkbox"/> Rad/Chemo/Blood therapy | |

Please check box if answer is YES:

- | | |
|---|--|
| <input type="checkbox"/> Is patient pregnant? | <input type="checkbox"/> Are you aware of an uncomfortable or bad bite? |
| <input type="checkbox"/> Has patient reached puberty? | <input type="checkbox"/> Do you have any jaw symptoms or headaches upon waking each morning? |
| <input type="checkbox"/> Any injuries to face, mouth, teeth? (circle) | <input type="checkbox"/> Have you had a blow to the jaw (trauma)? |
| <input type="checkbox"/> Thumb, finger, lip sucking? (circle) | <input type="checkbox"/> Have you ever been treated for a jaw or muscle or joint disorder? |
| <input type="checkbox"/> Mouth-breathing when awake, asleep? (circle) | <input type="checkbox"/> Does the patient smoke? |
| <input type="checkbox"/> Any missing/extra permanent teeth? | <input type="checkbox"/> Abnormal height and weight? |
| <input type="checkbox"/> Any teeth removed by extraction? | <input type="checkbox"/> Is patient adopted? Does he/she know? |
| <input type="checkbox"/> Is there a tongue-thrust problem? | <input type="checkbox"/> Latex allergy? |
| <input type="checkbox"/> Any speech problems? | <input type="checkbox"/> Cheek, tongue, or lip chewing? |
| <input type="checkbox"/> Any pain or clicking on opening mouth? | <input type="checkbox"/> Clenching teeth? |
| <input type="checkbox"/> Has an orthodontist been consulted previously? | <input type="checkbox"/> Grinding teeth? |
| <input type="checkbox"/> Reason: _____ | <input type="checkbox"/> Fingernail biting? |
| _____ | |
| _____ | |

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. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____ Witness _____

Updates (date & initial) _____