

## MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Is the patient in good health? Circle One YES NO  
 Is patient taking prescriptions or over the counter medications? YES NO Please list all prescriptions and medications: \_\_\_\_\_  
 If female, is the patient pregnant or possibly pregnant? YES NO  
 Under the care of a physician? YES NO Explain: \_\_\_\_\_  
 Physician name and phone number: \_\_\_\_\_  
 History of major illness? YES NO Describe: \_\_\_\_\_  
 Any sensitivities or allergies? YES NO List: \_\_\_\_\_  
 Have tonsils and/or adenoids been removed? YES NO When? \_\_\_\_\_  
 Any condition not listed that you would like the doctor to know about? \_\_\_\_\_  
 Has the patient had any of the following medical conditions? Please circle YES of NO

YES NO <b>ADD/ADHD</b>	YES NO <b>CANCER</b>	YES NO <b>HERPES</b>	YES NO <b>OSTEOPOROSIS/OSTEOPENIA</b>
YES NO <b>AUTISM SPECTRUM</b>	YES NO <b>COLD SORES</b>	YES NO <b>HEART MURMUR</b>	YES NO <b>PNUEMONIA</b>
YES NO <b>AIDS/ARC</b>	YES NO <b>DIABETES</b>	YES NO <b>HEART CONDITION</b>	YES NO <b>PSYCHIATRIC PROBLEM</b>
YES NO <b>ANEMIA</b>	YES NO <b>DIZZY SPELLS</b>	YES NO <b>KIDNEY PROBLEM</b>	YES NO <b>RADIATION TREATMENT</b>
YES NO <b>ANGINA</b>	YES NO <b>EPILEPSY</b>	YES NO <b>LIVER PROBLEM</b>	YES NO <b>RHEUMATIC FEVER</b>
YES NO <b>ARTHRITIS</b>	YES NO <b>FAINTING</b>	YES NO <b>HIGH BLOOD PRESSURE</b>	YES NO <b>TUBERCULOSIS</b>
YES NO <b>ASTHMA</b>	YES NO <b>FEVER BLISTERS</b>	YES NO <b>LOW BLOOD PRESSURE</b>	YES NO <b>ULCERS/COLITIS</b>
YES NO <b>BLOOD DISORDER</b>	YES NO <b>GI DISORDERS</b>	YES NO <b>LYME DISEASE</b>	YES NO <b>SNORING</b>
YES NO <b>BONE DISORDER</b>	YES NO <b>HEADACHES</b>	YES NO <b>NERVOUS DISORDER</b>	YES NO <b>OBSTRUCTIVE SLEEP APNEA</b>

## DENTAL HISTORY

Main orthodontic concern \_\_\_\_\_  
 Injuries to the face, mouth, or chin? YES NO Explain: \_\_\_\_\_  
 Pain/tenderness/locking of the jaw joint? YES NO Explain: \_\_\_\_\_  
 Concerning the following habits please circle YES or NO:

YES NO <b>Chewing/Eating problem</b>	YES NO <b>Nail biting</b>	YES NO <b>Clenching and/or grinding</b>
YES NO <b>Lip biting</b>	YES NO <b>Pen/Pencil biting</b>	YES NO <b>Tongue Thrusting</b>
YES NO <b>Mouth breathing</b>	YES NO <b>Speech Problems</b>	YES NO <b>Thumb/Finger sucking</b>

## SIGNATURE

I believe the information I have provided is correct to the best of my knowledge, that it will held in strict confidence and it is my responsibility to inform this office of any changes in my or my child's medical status.  
 I hereby authorize release of information related to insurance claims. I consent to examination by the doctor and I authorize payment of insurance benefits.  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient/Parent/Guardian yearly review

12 month \_\_\_\_\_ 24 month \_\_\_\_\_ 36 month \_\_\_\_\_  
Initial and date Initial and date Initial and date