

MEDICAL HISTORY

DENTAL HISTORY

Please check if patient has or has had

<input type="checkbox"/> [Y] <input type="checkbox"/> [N]	<input type="checkbox"/> [Y] <input type="checkbox"/> [N]
<input type="checkbox"/> <input type="checkbox"/> Joint swelling	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Bone disorders	<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Heart trouble	<input type="checkbox"/> <input type="checkbox"/> Epilepsy (convulsions)
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Prolonged bleeding
<input type="checkbox"/> <input type="checkbox"/> Rheumatic trouble	<input type="checkbox"/> <input type="checkbox"/> Faintness/Dizziness
<input type="checkbox"/> <input type="checkbox"/> Thyroid problems	<input type="checkbox"/> <input type="checkbox"/> Tonsils removed
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Adenoids removed
<input type="checkbox"/> <input type="checkbox"/> Emotional problems	<input type="checkbox"/> <input type="checkbox"/> Sore throats
<input type="checkbox"/> <input type="checkbox"/> Brain injury	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Kidney or liver involvement	<input type="checkbox"/> <input type="checkbox"/> Earaches
<input type="checkbox"/> <input type="checkbox"/> Joint Prosthesis	

Has any member of the family or close relative had:

<input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/> <input type="checkbox"/> Lupus

List any other serious illnesses:

List any allergies:

List drugs or medications now being taken:

Is patient presently under physician's care? Yes No
Reason:

Name of physician

Please check Yes or No

<input type="checkbox"/> [Y] <input type="checkbox"/> [N]
<input type="checkbox"/> <input type="checkbox"/> Any injuries to face, mouth, teeth? (circle)
<input type="checkbox"/> <input type="checkbox"/> Thumb, finger, lip sucking? (circle)
<input type="checkbox"/> <input type="checkbox"/> More than average amount of decay?
<input type="checkbox"/> <input type="checkbox"/> Any missing permanent teeth?
<input type="checkbox"/> <input type="checkbox"/> Any extra permanent teeth?
<input type="checkbox"/> <input type="checkbox"/> Any teeth removed by extraction?
<input type="checkbox"/> <input type="checkbox"/> Any difficulty in swallowing or chewing?
<input type="checkbox"/> <input type="checkbox"/> Any pain or clicking on opening mouth?
<input type="checkbox"/> <input type="checkbox"/> Is patient adopted? At what age? _____
<input type="checkbox"/> <input type="checkbox"/> Does patient visit dentist regularly? Date of last visit _____
<input type="checkbox"/> <input type="checkbox"/> Has an orthodontist been consulted previously?

Reason

Approximately how much has patient grown in the last year?

What would you like to have orthodontic treatment accomplish?

Adolescent Females: Has menstruation begun? Yes No
Date (month/year)_____

Patient's attitude toward orthodontic treatment:
(circle one) Very motivated Will cooperate if needed Not motivated