Medical History

What is your main orthodontic concern? _____

Have you ever been evaluated or had orthodontic treatment before? _____ yes _____ no

Have there been any injuries to the face, mouth, teeth or chin? _____ yes _____ no

Have adenoids or tonsils been removed? _____ yes _____ no

Do you have any missing or extra permanent teeth? _____ yes _____ no

Do you brush your teeth daily? _____ yes _____ no

Do you floss your teeth daily? _____ yes _____ no

Are you currently under the care of a physician? _____ yes _____ no

Please describe your current physical health: Good Fair Poor

Please list any/all drugs that you are currently taking: _____

Please list any/all drugs that you are allergic to: _____

Have you ever had any of the following medical problems?

Y	N	Abnormal bleeding	Y	N	Diabetes
Y	N	Allergies to any drugs	Y	N	Handicaps / Disabilities
Y	N	Allergic to Latex / Metals	Y	N	Hearing Impairment
Y	N	Allergic to Plastic	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

If you answered yes to above questions, please explain:

_____

Do / Did you have any of the following habits?

Y	N	Clenching/ Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Lip Sucking / Biting	Y	N	Speech Problems
Y	N	Mouth Breathing	Y	N	Thumb / Finger Sucking
Y	N	Nail Biting	Y	N	Tongue Thrusting

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes to my medical status.

_____

Signature Date