



**PATIENT DENTAL HISTORY**

Dentist's Name \_\_\_\_\_ Date of last dental exam \_\_\_\_\_  
Have there ever been any injuries to the face, mouth or teeth? Yes \_\_\_ No \_\_\_  
Has patient ever sucked your fingers or thumb? Until what age? Yes \_\_\_ No \_\_\_  
Does patient have any speech problems? Yes \_\_\_ No \_\_\_  
Is patient a mouth breather? While awake? Yes \_\_\_ No \_\_\_  
While asleep? Yes \_\_\_ No \_\_\_  
Has patient informed of any missing or extra permanent teeth? Yes \_\_\_ No \_\_\_  
Has patient consulted an orthodontist previously? Yes \_\_\_ No \_\_\_  
Did either parent have orthodontic treatment? Yes \_\_\_ No \_\_\_  
Does patient have pain in the jaw joints? Yes \_\_\_ No \_\_\_  
Does patient have popping or cracking of the jaw joints? Yes \_\_\_ No \_\_\_  
When did this begin? \_\_\_\_\_  
Does patient have headaches? Frequency \_\_\_\_\_ Location \_\_\_\_\_

**MEDICAL HISTORY**

Is patient in good health? Yes \_\_\_ No \_\_\_  
Does patient have any history of major illness? Yes \_\_\_ No \_\_\_  
Has patient ever been under the care of a physical for illness? Yes \_\_\_ No \_\_\_  
Please explain any pertinent medical history: \_\_\_\_\_  
Does patient have tendency to colds? Yes \_\_\_ No \_\_\_ Sore throats? Yes \_\_\_ No \_\_\_ Ear infection? Yes \_\_\_ No \_\_\_  
Have tonsils and/or adenoids been removed? Yes \_\_\_ What age? \_\_\_ No \_\_\_  
Does patient smoke? Yes \_\_\_ No \_\_\_ How much? \_\_\_\_\_  
List any allergies: \_\_\_\_\_  
What medications are now being taken. Please give reasons \_\_\_\_\_  
If patient is a child, has patient reached puberty? Yes \_\_\_ No \_\_\_  
Does patient wear contact lenses? Yes \_\_\_ No \_\_\_  
Does patient gag easily? Yes \_\_\_ No \_\_\_  
Is patient pregnant? Yes \_\_\_ No \_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Physician's Name \_\_\_\_\_ City \_\_\_\_\_ Date of last exam \_\_\_\_\_

Does the patient have or had any of the following? Please indicate with an X

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bone Disorders
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Involvement	<input type="checkbox"/> Endocrine Problems
<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Liver Involvement	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Radiation Treatments
<input type="checkbox"/> Allergies to anesthetics	<input type="checkbox"/> Allergies to medicines or drugs	
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Malignancies
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Psychiatric care
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> Typhoid fever	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Other		

Comments \_\_\_\_\_  
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