

Medical History

Has Patient had any of the following:

Yes No

- | | Yes | No |
|------------------------------------|--------------------------|--------------------------|
| Aids (or tested HIV positive)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco Use..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine or Thyroid Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone Disorders..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Prolonged Bleeding..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Removal of Tonsils & Adenoids..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient is in good health.....

Patient is under physician's care.....

If so, for what reason _____

Are there any impending medical conditions.....

If so, describe _____

Patient is taking prescription medications.....

If so, list _____

Patient's height _____ weight _____

For females only;

Is the patient presently pregnant.....

Does the patient take birth control pills.....

For children and adolescence only:

Has puberty been reached (start of menstruation or voice change)

If so, and within the last two years, when? _____

Does patient require pre-medication or antibiotics

before dental appointments.....

Dental History

Yes No

- | | | | |
|---|--------------------------|--------------------------|-----------------------|
| Patient has had a recent dental check-up..... | <input type="checkbox"/> | <input type="checkbox"/> | Date _____ |
| Any missing or extra permanent teeth..... | <input type="checkbox"/> | <input type="checkbox"/> | (For office use only) |
| Blow or injury to face or teeth..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Night time teeth clenching or grinding habit..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Speech problem..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Clicking or pain when opening jaws..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Frequent mouth breathing - while awake..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Frequent mouth breathing - while asleep..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Surgery to repair cleft lip and/or cleft palate..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High intake of sweets..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Has an orthodontist been consulted previously..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Has either parent had orthodontic treatment..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Has patient ever sucked a thumb or fingers? Until what age..... | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| In your own words, what is the dental problem _____ | | | _____ |
| _____ | | | _____ |
| _____ | | | _____ |

If you have any additional concerns or questions you wish the Doctor to be aware of or you wish the Doctor to answer, please describe:
