Medical History

Has Patient had any of the following:

	Yes	No
Aids (or tested HIV positive)	❑	❑
Cancer	❑	❑
Tobacco Use	❑	❑
Ulcers	❑	❑
Asthma	❑	❑
Anemia	❑	❑
Diabetes	❑	❑
Fainting	❑	❑
Nervous Problems	❑	❑
Hepatitis	❑	❑
Rheumatic Fever	❑	❑
Glaucoma	❑	❑
Convulsions	❑	❑
Kidney Problems	❑	❑
Endocrine or Thyroid Problems	❑	❑
Bone Disorders	❑	❑
Prolonged Bleeding	❑	❑
Liver Problems	❑	❑
Allergies	❑	❑
Removal of Tonsils & Adenoids	❑	❑
Frequent Headaches	❑	❑
Heart Murmur	❑	❑
Mitral Valve Prolapse	❑	❑

	Yes	No
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	❑	❑
Any missing or extra permanent teeth	❑	❑
Blow or injury to face or teeth	❑	❑
Night time teeth clenching or grinding habit	❑	❑
Speech problem	❑	❑
Clicking or pain when opening jaws	❑	❑
Frequent mouth breathing - while awake	❑	❑
Frequent mouth breathing - while asleep	❑	❑
Surgery to repair cleft lip and/or cleft palate	❑	❑
High intake of sweets	❑	❑
Has an orthodontist been consulted previously	❑	❑
Has either parent had orthodontic treatment	❑	❑
Has patient ever sucked a thumb or fingers? Until what age_____	❑	❑

Date_____

(For office use only)

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_____

In your own words, what is the dental problem _____

_____

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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:

_____

_____

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_____