

Please Describe Why You Sought This Consultation _____

MEDICAL HISTORY

Now or in the past, have you had:

	YES	NO		YES	NO
BIRTH DEFECTS	<input type="checkbox"/>	<input type="checkbox"/>	BONE FRACTURES OR MAJOR INJURIE:	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECTS OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	FACE, HEAD, NECK INJURIES	<input type="checkbox"/>	<input type="checkbox"/>
HIGH OR LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	NERVE OR BRAIN DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK/STROKE/ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES OR MIGRAINES	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN/SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES, FAINTING, NERVE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
SKIN DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>	BONE DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS OR OTHER LIVER PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS (ANY TYPE)	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES OR LOW SUGAR	<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA	<input type="checkbox"/>	<input type="checkbox"/>
ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	VISION, HEARING, SPEECH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
HERPES (ANY TYPE)	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA, SINUS PROBLEMS, HAYFEVER	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV POSITIVE	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNE SYSTEM PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
CANCER OR TUMOR	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE OR THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF OSTEOPOROSIS	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS OR PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF EATING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
FREQUENT EAR/THROAT INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	TONSIL OR ADENOID CONDITION	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had allergies or reactions to any of the following? NO KNOWN ALLERGIES

LOCAL ANESTHETICS (NOVACAINE, LIDOCAINE, ETC.) LATEX ASPIRIN PENICILLIN OTHER

AN PICS METAL MELRY, NICH :TC.) ACRY PLAN LLENS ANIMALS

FOODS OTHER SUBSTANCES

Comments _____

Please list any other significant information about your medical history _____

DENTAL HISTORY

Now or in the past, have you had:

	YES	NO		YES	NO
PERMANENT TEETH REMOVED	<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL EXTRA OR MISSING TEETH	<input type="checkbox"/>	<input type="checkbox"/>
CHIPPED OR INJURED TEETH	<input type="checkbox"/>	<input type="checkbox"/>	SENSITIVE OR SORE TEETH	<input type="checkbox"/>	<input type="checkbox"/>
LOST OR BROKEN FILLINGS	<input type="checkbox"/>	<input type="checkbox"/>	JAW FRACTURES, CYSTS, INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>
ROOT CANALS OR PULPOTOMIES	<input type="checkbox"/>	<input type="checkbox"/>	PERIODONTAL (GUM) DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH PROBLEMS/SPEECH THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	MOUTH BREATHING HABIT/SNORING	<input type="checkbox"/>	<input type="checkbox"/>
ORAL HABITS (SUCKING THUMB, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	GRINDING OR CLENCHING	<input type="checkbox"/>	<input type="checkbox"/>
LOCKING IN JAW JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	CLIPPING, TIGHT JAW/FACE MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>

Comments _____

Please list any other significant information about your dental history _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health. I hereby consent to the taking of x-rays, photographs and other necessary records before, during and after treatment.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____