PATIENT HISTORY FORM

Patient's (First, Middle, Last)
Name ____________________ Sex____ Age______ Birthdate__________

Patient's
Address____________________ E-Mail____________________

____________________ Home Phone#____________________

Cell Phone#____________________

Patient's Employer ____________________ Work Phone # ____________________

Occupation and title____________________

Spouse's Name ____________________ Cell Phone #____________________

Spouse's Employer ____________________ Work Phone # ____________________

Occupation and title____________________

Any family member in treatment or treated here? ____________________

How did you first become aware of your need for orthodontic treatment? ____________________

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Referred by____________________ Dental/Ortho Insurance Y N ____________________

DENTAL HISTORY AND DEVELOPMENT QUESTIONAIRE

Patient's
D.D.S. Name/Address____________________ D.D.S. Phone____________________

Previous Ortho-
dontic Treatment Y N Length of Treatment________ Orthodontist____________________

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Comments on any
Dental Trauma: ____________________

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1. Any problems with your teeth or gums? Y N
   ____
2. Last dental visit?____________________
3. Any trouble with previous dental treatment? Y N (if yes, please specify)
   ____
   ____
4. Any problems with speech? Y N (if yes, please specify)
   ____
   ____
5. Do you grind or clench your teeth? Y N
6. Do you primarily breathe through your mouth? Y N
7. Any problems with frequent jaw clicking, jaw popping headaches, or neck aches? Y N

Primary Dental Concerns:

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Primary Orthodontic Concerns:

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PATIENT HISTORY FORM, CONT.

Patient's (First, Middle, Last)

Name ____

MEDICAL HISTORY

Operations:
Tonsils removed? Y N   Adenoids removed? Y N

Other ____

Presently taking any Medications? Y N   What Meds ____________________   For What ____________________

Any Medical Issues that require antibiotics before dental procedures? ____________________

Allergies: Any known allergies to Medications? Y N   If yes, what meds? ____________________

Do you have any known allergies to Nickel? Y N   Latex? Y N

Other allergies? ____

Now or in the past, have you had:

1. Birth defects or hereditary problems? Y N
2. Bone fractures, any major accidents? Y N
3. Rheumatoid or arthritic conditions? Y N
4. Endocrine or thyroid problems? Y N
5. Kidney problems? Y N
6. Diabetes? Y N
7. Cancer, tumor, radiation treatment or chemotherapy? Y N
8. Stomach ulcer or hyperacidity? Y N
9. Polio, mononucleosis, tuberculosis, pneumonia? Y N
10. Problems of the immune system? Y N
11. AIDS or HIV positive? Y N
12. Hepatitis, jaundice or liver problem? Y N
13. Fainting spells, seizures, epilepsy or neurological problem? Y N
14. Mental health disturbance or depression? Y N
15. Vision, hearing, tasting or speech difficulties? Y N
16. Loss of weight recently, poor appetite? Y N
17. History of eating disorder (anorexia, bulimia) Y N
18. Excessive bleeding or bruising tendency, anemia or bleeding disorder? Y N
19. High or low blood pressure? Y N
20. Tire easily? Y N
21. Chest pain, shortness of breath or swelling ankles? Y N
22. Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)? Y N
23. Skin disorder? Y N
24. Frequent headaches, colds or sore throats Y N
25. Eye, ear, nose or throat condition? Y N
26. Hay fever, asthma, sinus trouble or hives? Y N
27. Tonsil or adenoid conditions? Y N
28. Osteoporosis? Y N
29. Height of birth parent: Mother______ Father______

Patient's M.D. ____________________   M.D. Phone ____________________

M.D. Address ____

<u>If you answered "yes" to any of the questions above, please provide details below and specify the question number.</u>

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To the best of my knowledge the above is complete and correct. I hereby give permission for dental treatment to be accomplished and for the development of photographic recordings of the conditions and treatment for the advancement of Dental Science through use in professional publications, lectures or television presentations.

____________________   ____________________
Signature (patient, parent or guardian)   Date