

4. MEDICAL HISTORY *continued*

Have you ever had any of the following diseases or medical problems?

- | | |
|--------------------------------------|----------------------------------|
| Y N Anemia/Radiation Treatment | Y N Heart Surgery/Pacemaker |
| Y N Artificial Bones/Joints | Y N Hemophilia/abnormal bleeding |
| Y N Artificial Valves | Y N Hepatitis |
| Y N Asthma | |
| Y N Arthritis | Y N High/Low Blood Pressure |
| Y N Blood Transfusion | Y N HIV +/-AIDS |
| Y N Cancer/Chemotherapy | Y N Past Hospitalization |
| Y N Congenital Heart Defect | Y N Kidney Problems |
| Y N Diabetes/Tuberculosis | Y N Mitral Valve Prolapse |
| Y N Difficulty Breathing | Y N Psychiatric Problems |
| Y N Drug/Alcohol Abuse | Y N Rheumatic/Scarlet Fever |
| Y N Emphysema/Glaucoma | Y N Severe/Frequent Headaches |
| Y N Epilepsy/Seizure/Fainting Spells | Y N Shingles |
| Y N Fever Blisters/Herpes | Y N Sinus Problems |
| Y N Heart Attach/Stroke | Y N Ulcers/Colitis |
| Y N Heart Murmur | Y N Veneral Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- Y N Aspirin Y N Dental Anesthetics Y N Penicillin

5. DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?

Have you ever been evaluated for orthodontic treatment?

- Yes No

Have you ever had a serious/difficult problem associated with any previous dental work?

- Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is:

- Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

Have you ever had an injury to your: Mouth Teeth Chin

Do you have any speech problems?

Do you generally breathe through your mouth?

- Y N Awake? Y N Asleep?

Do you have any missing or extra permanent teeth?

- Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I verbally retrieved the medical / dental information above with the patient named herein.

Doctor's Comments

Initials: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY