

PATIENT HISTORY INFORMATION

Patient's Name _____ Nickname _____ Sex _____
Home Address _____ Date of Birth _____
Home Phone _____ School (If applicable) _____

Information for patients who are minors:

FATHER

MOTHER

Name _____
Address _____

Name _____
Address _____

Business Phone _____
Cell Phone _____

Business Phone _____
Cell Phone _____

Parent's Marital Status: Married ___ Separated ___ Divorced ___ Widowed ___

Information for adult patients:

Occupation _____ Business Phone _____ Cell Phone _____
Name of Spouse _____ Spouse's Business Phone _____
Children's Names and Ages _____
E-mail _____ Alternate E-mail _____

MEDICAL HISTORY

Is the patient experiencing any health problems? Yes ___ No ___ Reason _____
Any major or unusual illnesses? Yes ___ No ___ Explain _____
Currently under physician's care? Yes ___ No ___ Reason _____
Currently taking medication? Yes ___ No ___ List _____
Allergies? Yes ___ No ___ List _____
Drug sensitivity/allergies? Yes ___ No ___ List _____
Patient's Physician: _____ Physician's Phone: _____

Please Check if Patient Has or Had any of the Following:

_____ Heart Murmur	_____ Has the patient ever been advised to take antibiotics prior to dental treatment?	
_____ Anemia	_____ Heart disease	_____ Frequent colds or flu
_____ Blood Disease	_____ Tuberculosis	_____ Mouth breathing
_____ Prolonged bleeding	_____ Endocrine Problems	_____ Tonsillitis
_____ Diabetes	_____ Jaundice	_____ Tonsils Removed: Age _____
_____ Hepatitis	_____ Bone Disorders	_____ Adenoid or Sinus Infections
_____ Rheumatic Fever	_____ Asthma	_____ Adenoids Removed: Age _____
_____ Herpes	_____ Epilepsy/Seizure Disorder	_____ AIDS/AIDS Related Complex

Is there any possibility that the patient could be pregnant? _____
Adolescent females only: Has the patient started having menstrual cycles? _____ When _____?

DENTAL HISTORY

Name of local dentist patient sees for cavity checkups/restorative dentistry _____
Has the patient had any severe jaw or facial injuries? _____ Explain _____
Has the patient had any injuries to teeth? _____ Explain _____
Has the patient had a history of thumb or finger sucking? _____ Explain _____
Has the patient consulted an orthodontist previously? _____
Are you satisfied with the prior treatment? _____

Has there ever been a history of:

_____ Clenching Teeth _____ Muscular Soreness around head/neck _____ Jaw Joint Soreness _____ Jaw Popping
_____ Grinding Teeth _____ Excessive Headaches _____ Jaw Joint Clicking _____ Ringing in the ears

Is there any other information that may be helpful? _____
Why are you seeking an orthodontic consultation? (What problems require correction?) _____

Signed _____ Date _____