Patient Name:___________________________
Form Completed by:______________________
Relation to Patient:_____________________

Complete and Bring to Exam Appointment

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MEDICAL HISTORY

Please Check If Patient Has or Has Had The Following:

[ ] Joint Swelling
[ ] Bone Disorders
[ ] Heart Trouble
[ ] Mitral Valve Prolapse
[ ] Rheumatic Fever
[ ] Diabetes
[ ] Emotional Problems
[ ] Brain Injury
[ ] Kidney or Liver Involvement
[ ] Joint Prosthesis

Have you or any of your family members had:

[Y] [N] Rheumatoid Arthritis?
[Y] [N] Lupus?
____
____

[ ] Tuberculosis
[ ] Anemia
[ ] Epilepsy (Convulsions)
[ ] Prolonged Bleeding
[ ] Faintness/Dizziness
[ ] Tonsils Removed
[ ] Adenoids Removed
[ ] Sore Throat
[ ] Tonsillitis
[ ] Earaches
[ ] Arthritis
[ ] Thyroid Problems
[ ] Chronic Disease's
[ ] AIDS
[ ] Hepatitis
[ ] Other

On Items Checked, Please Provide A More Detailed Description:

____

Is Patient presently under Physician Care for any reason?

____

Name of Primary Physician/Pediatrician:_________________________

Is The Patient Adopted/ At what age? ___________________________

Adolescent Females: Has Menstruation begun? [Y] [N]

Date Month/Year____________________

Adolescent boys: Has voice changed? [Y] [N]

DENTAL HISTORY

Please Check If Patient Has or Has Had The Following:

[ ] Any Injuries to Face, Mouth, or Teeth?

[ ] Thumb, Finger, OR Lip Sucking?

Does The Patient Visit The Dentist Regularly? [Y] [N]

Date of Last Visit__________

Names of Dentists or Dental Specialists:

____
____

Mastication Related To Malocclusion

[ ] Extreme grimacing or excessive motions of the facial muscles during swallowing

[ ] Socially unacceptable behavior during eating because of necessary compensation or facial deviations

[ ] Popping or locking in the jaw joint

[ ] Do you have a history of headaches?

Respiration and Speech Related To Malocclusion

[ ] Breathing Difficulties

[ ] Chronic Mouth Breathing

[ ] Lisping or Other Speech Errors in Children 9 Years or Older

[ ] History of or Recommendation for Speech Therapy

List Drugs or Medications Now Being Taken:____________________

Has Patient Ever Been Advised To Take Antibiotics Prior To Dental Care? [Y] [N]

Females: Pregnant? [Y] [N]

If Yes, Please List: _______________________________________

List Any Allergies: ______________Metal or Latex (Circle)

Signature____ **Date**____

Please note it is the responsibility of the parent/patient to advise our office immediately if any changes occur for the above History.

Internal Office: Reviewed by: _________________________ Date: _____________________