Dental/TMJ History

Dentist_____ Date of last cleaning_____ How often do you brush? _____ floss? _____

Please check if you have or have had any of the following:

___Bleeding/swollen gums	___Headaches (severe/frequent)	___Missing or extra teeth	___Root canal(s)
___Broken/chipped tooth	___Injury to mouth/teeth/chin	___Mouth breather	___Sensitive tooth or gums
___Cleft palate/lip	___Jaw pain, click, pop or lock	___Nail biting	___Thumb/finger sucking
___Grinding/clenching	___Lip or cheek biting	___Periodontal problems	___Tongue thrust

Other_____

Ever evaluated or had orthodontic TX before? _____ If yes, explain _____

Attitude toward treatment_____ Attitude toward braces_____

May we request medical or dental records if necessary? _____ May we use orthodontic records for presentations? _____

Medical History

Doctor or clinic_____ #_____ Date of last visit_____

Please check if you have or have had any of the following diseases, medical conditions or procedures:

___ **Allergies**
- ___Latex
- ___Metal _____
- ___Nickel
- ___Other_____

___ADD/ADHD/Hyperactive
___Autism/Asperger
___Arthritis/Rheumatism
___**Artificial bone/joint/implant**
___Asthma/sinus problems
___Back/neck problems
- ___Swollen neck glands

___Birth defects
- ___Cerebral palsy
- ___Down syndrome
- ___Other_____

___**Blood problems/disease**
- ___**Abnormal bleeding**
- ___**Anemia**
- ___**Hemophilia**
- ___**Hepatitis type _____**
- ___**High/low blood pressure**
- ___**HIV+/AIDS/ARC**

___Cancer/tumor head or neck
- ___Chemotherapy/radiation

___Chicken pox/measles/mumps
___Circulatory problems
___Diabetes/hypoglycemia
___Drug/alcohol abuse
___Earaches/Hearing problems
___**Epilepsy/seizures**
___**Fainting/dizziness**
___Fever blisters/herpes
___Handicap/disability_____
___**Heart problems**
- __**Congenital heart defect**
- __**Artificial valve**
- __**Heart murmur/premed Y N**
- __**Mitral valve prolapse**
  Premed Y N
- __**Surgery/pacemaker**

___Kidney/Liver/Organ problems
___Mononucleosis
___Nervous problems
___**Osteopenia/Osteoporosis***
(see below)

___Psychiatric/emotional problems
___Respiratory problems
___**Rheumatic fever**
___Scarlet fever
___Scoliosis
___Shortness/difficulty breathing
___**Sleep apnea**
___Stomach problems/Ulcer
___Stroke
___Surgeries/operations_____
___Swelling feet/ankles
___Thyroid problems
___Tobacco habit
___Tonsillitis
___Tonsils/adenoids removed
___**Tuberculosis TB**
___Vertigo
___**Other_____**
_____
_____
_____

***Are you now taking, or have taken in the past, medications known as "bisphosphonates"? Y N (ex: Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, or Zometa) If yes, explain_____**

Further explain any past medical problems, hospitalizations, illnesses, or operations (give approximate date):

_____

_____

Discuss any current medical problems: _____

Medications you are currently taking: _____

Pre-medication needed before dental work: _____ Dosage_____

Pharmacy_____ Phone_____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the orthodontist to determine appropriate treatment and I agree to notify the orthodontist if any change in health status should occur. I authorize the orthodontic staff to perform any necessary orthodontic services, with my informed consent, that the patient may need during diagnosis and treatment. I agree to be responsible for payment of all services rendered on behalf of myself and my dependents.

Signature of patient (or parent/guardian if minor) _____ Date_____

Thank you for filling out this form completely. Our office would like to welcome you into our family of friends!!!!