We care about your total health and appreciate your time in completing this health history.

Medical History

Physician _____ Date of last visit _____

Address _____ Phone _____
Street City State Zip

Please circle YES or NO (If YES, please fill in details)

YES NO Are you currently taking any medication? _____
YES NO Are you allergic to any medication? _____
YES NO Do you have a history of major illness? _____
YES NO Have you had any major operations? _____
YES NO Growth Assessment – If a child has he/she reached puberty? Girls – Reached menarche? Y or N
Boys – Voice changed? Y or N

Please circle any of the medical conditions below that you have had or currently have.

AIDS	Bone Disorders	Gastrointestinal Disorders	High Blood Pressure	Pneumonia
Anemia	Bleeding Disorders	Heart Problems	Kidney Involvement	Rheumatic Fever
Arthritis	Diabetes	Hepatitis	Liver Involvement	Tuberculosis
Asthma/Hayfever	Epilepsy	Herpes	Nervous Disorders	Tumor or Cancer

Are there any medical conditions you feel we should be made aware of? _____

Dental History

Dentist _____ Date of last visit _____

Address _____ Phone _____
Street City State Zip

What are your orthodontic concerns? _____

Please circle YES or NO (If YES, please fill in details)

YES NO Have you ever had an unfavorable dental experience? _____
YES NO Have you ever had any injuries to your face, mouth, or teeth? _____
YES NO Is any part of your mouth sensitive to temperature or pressure? _____
YES NO Do your gums bleed when you brush? _____
YES NO Do you have a thumb or tongue habit? _____
YES NO Do you primarily breathe through your mouth? _____
YES NO Have you ever seen an orthodontist? _____
YES NO Has anyone in the family received orthodontic treatment? _____
How did he/she/they feel about the result? _____
What is your attitude toward receiving orthodontic treatment? _____
YES NO Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____
YES NO Are you aware of your jaw clicking or popping? _____
YES NO Have you ever been told that you grind your teeth? _____
YES NO Are you happy with the overall size, shape, and color of your teeth? _____
YES NO Are you aware that some appointments will be during school/work hours? _____

Benefits of Orthodontics

Orthodontics is a service that provides an improvement in the appearance of the teeth and their general health and function. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I hereby state that I have read and understand the above paragraph and that I have truthfully to the best of my ability answered all the above questions.

_____ _____
Patient/Parent Date