MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? _____ YES ❑ NO ❑

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ YES ❑ NO ❑

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? _____ YES ❑ NO ❑

PLEASE LIST _____

_____

DOES PATIENT HAVE TENDENCY TO COLDS ❑ SORE THROATS ❑ EAR INFECTIONS ❑

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ YES ❑ NO ❑

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS: _____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

HAS THE PATIENT REACHED PUBERTY? GIRLS - HAS SHE STARTED MENSTRUATION? YES ❑ NO ❑

BOYS - HAS HIS VOICE CHANGED? YES ❑ NO ❑

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ YES ❑ NO ❑

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES ❑ NO ❑

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES ❑ NO ❑

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ YES ❑ NO ❑

WHILE ASLEEP? _____ YES ❑ NO ❑

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES ❑ NO ❑

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ YES ❑ NO ❑

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES ❑ NO ❑

LIST ANY MUSICAL INSTRUMENT PLAYED: _____

REASON FOR CONSULTATION _____

_____

HIPAA CONSENT: I HAVE BEEN INFORMED OF THE NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient Signature *Guardian if under age 18*

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

DIABETES ..... ❑
PNEUMONIA ..... ❑
HEART TROUBLE ..... ❑
RHEUMATIC FEVER ..... ❑
BONE DISORDERS ..... ❑
ENDOCRINE PROBLEMS ..... ❑
CANCER ..... ❑
HIV+/AIDS ..... ❑
HEARING IMPAIRMENT ..... ❑
ANY OPERATIONS ..... ❑
ANY STAYS IN A HOSPITAL ..... ❑
PROLONGED BLEEDING ..... ❑
FAINTING OR DIZZINESS ..... ❑
NERVOUS DISORDERS ..... ❑
LIVER INVOLVEMENT ..... ❑
TUBERCULOSIS ..... ❑
ANEMIA ..... ❑
EPILEPSY ..... ❑
ASTHMA ..... ❑
KIDNEY INVOLVEMENT ..... ❑

HEIGHT _____

WEIGHT _____

Date: _____

Diagnosis & Treatment Plan: _____

_____

_____

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_____

Appt. Availability: _____

_____

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_____

Estimate & Payment Plan: _____

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