NAME- _____ **DATE- _____**

Your answers are for office records only, and are confidential. A thorough medical history is essential to complete orthodontic evaluation. For the following questions mark Yes, No or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in past, have you had:

☐Yes ☐No ☐ dk/u Birth defects or hereditary problem?
☐Yes ☐No ☐ dk/u Any Injuries to face, head, and neck?
☐Yes ☐No ☐ dk/u Arthritics or joint problem?
☐Yes ☐No ☐ dk/u Endocrine or thyroid problems?
☐Yes ☐No ☐ dk/u Diabetes or low sugar?
☐Yes ☐No ☐ dk/u Kidney problems?
☐Yes ☐No ☐ dk/u Cancer, tumour, radiation treatment or chemotherapy?
☐Yes ☐No ☐ dk/u Stomach ulcer, hyperacidity, acid reflux?
☐Yes ☐No ☐ dk/u Immune system problems?
☐Yes ☐No ☐ dk/u History of osteoporosis?
☐Yes ☐No ☐ dk/u Gonorrhoea, syphilis, herbs, AIDS or HIV positive?
☐Yes ☐No ☐ dk/u Hepatitis, jaundice or other liver problem?
☐Yes ☐No ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐Yes ☐No ☐ dk/u Seizures, fainting spells, neurologic problem?
☐Yes ☐No ☐ dk/u vision, Speech or hearing problem?
☐Yes ☐No ☐ dk/u Mental health disturbance or depression?
☐Yes ☐No ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐Yes ☐No ☐ dk/u High or low blood pressure?
☐Yes ☐No ☐ dk/u Excessive bleeding or bruising anaemia?
☐Yes ☐No ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐Yes ☐No ☐ dk/u Heart defects, heart murmur, and rheumatic heart attack?
☐Yes ☐No ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐Yes ☐No ☐ dk/u Skin disorder (other than common acne)?
☐Yes ☐No ☐ dk/u Frequent headaches or migraines?
☐Yes ☐No ☐ dk/u Asthma, sinus problem, hayfever?
☐Yes ☐No ☐ dk/u Tonsil adenoid condition?
☐Yes ☐No ☐ dk/u Do you frequently breathe though your mouth?

DENTAL HISTORY

Now or in the past, have you had?

☐Yes ☐No ☐ dk/u Permanent or extra (supernumerary) teeth removed?
☐Yes ☐No ☐ dk/u Supernumerary (extra) or congenitally missing teeth?
☐Yes ☐No ☐ dk/u Chipped or injured primary or permanent teeth?
☐Yes ☐No ☐ dk/u Any sensitive or sore teeth?
☐Yes ☐No ☐ dk/u Bleeding gums, bad taste or mouth odour?
☐Yes ☐No ☐ dk/u Jaw fractures, cysts, infections?
☐Yes ☐No ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐Yes ☐No ☐ dk/u "Gum boils", frequent canker sores or cold sores?
☐Yes ☐No ☐ dk/u History of speech problems or speech therapy?
☐Yes ☐No ☐ dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
☐Yes ☐No ☐ dk/u Food impaction between the teeth?
☐Yes ☐No ☐ dk/u Teeth causing irritation to lips, cheek or gums?
☐Yes ☐No ☐ dk/u Abnormal swallowing (tongue thrust)?
☐Yes ☐No ☐ dk/u Tooth grinding or clenching?
☐Yes ☐No ☐ dk/u Clicking, locking in jaw joints?
☐Yes ☐No ☐ dk/u Soreness in jaw muscles or face muscles?
☐Yes ☐No ☐ dk/u Ringing in ears, difficulty in chewing or opening jaw?
☐Yes ☐No ☐ dk/u Have you ever been treated for "TMJ" or "JMD" problem?
☐Yes ☐No ☐ dk/u Any broken or missing fillings?
☐Yes ☐No ☐ dk/u Any serious trouble associate with previous dental treatment?
☐Yes ☐No ☐ dk/u Have you ever been diagnosed with gum disease or pyorrhoea?

Have you had allergies or reactions to any of the following?

☐Yes ☐ No ☐ dk/u Skin allergies such as latex
☐Yes ☐No ☐ dk/u Medications such as Aspirin, Ibuprofen (Motrin, Advil), Penicillin, other antibiotics?
☐Yes ☐No ☐ dk/u Metals (jewellery, clothing snaps)
☐Yes ☐No ☐ dk/u Plant pollens, Animals, Food?
☐Yes ☐No ☐ dk/u seasonal allergies

Other substances _

For Women

Are you pregnant? If Yes, List any medications you are taking".

_ _

_ _

_ _

Print... Save... Send...