HEALTH HISTORY

(Please complete Both Sides before exam appointment and bring with you)

Patient Name _____ Birthdate _____SS# _____

Address _____

Home Telephone _____ Work Phone _____ Emerg Contact _____

Family Physician _____ General Dentist _____

Significant Medical History and current problems:

[ ] Birth Defect or trauma _____
[ ] Motor Vehicle Accident _____
[ ] Facial Injury _____
[ ] Major Illness or Surgery _____
[ ] Contact with AIDS, Hepatitis, or Tuberculosis _____
[ ] Current problem requiring medical care _____

Please circle all that may apply :

Anemia, Arthritis, Asthma, Bone Disorders, Diabetes, Dizziness, Endocrine Disorders, Epilepsy, Fainting, Growth Problems, Heart Problems, High or Low Blood Pressure, Kidney Problems, Liver Problems, Nervous Problems, Rheumatic Fever, Scarlet Fever

Please Explain: _____
_____
_____

General Health : _____

Breathing Problems / Allergies :_____

Medications : _____

Frequency of use of Aspirin/Tylenol/Motrin/etc .....[ ] Daily.....[ ] Weekly.....[ ] Seldom

Dental - Has there ever been any:

Pain in either jaw joint?.....	[ ] Yes	[ ] No
Injury to the face mouth, teeth or jaws?	[ ] Yes	[ ] No
Clicking, popping, locking, or dislocation of either jaw joint?.....	[ ] Yes	[ ] No
Limitation of jaw movement or function?	[ ] Yes	[ ] No
Inability to breathe comfortably with the lips closed?	[ ] Yes	[ ] No
Jaw soreness or headaches with function?	[ ] Yes	[ ] No
Permanent teeth removed?	[ ] Yes	[ ] No
Orthodontic care prior to this time?	[ ] Yes	[ ] No
Finger or thumb habit or tongue problem?	[ ] Yes	[ ] No
Problem with sore or bleeding gums or Periodontal care?	[ ] Yes	[ ] No
History of grinding or clenching the teeth / jaws?	[ ] Yes	[ ] No
Missing or extra teeth?	[ ] Yes	[ ] No

Please Explain: _____
_____

(Please complete Both Sides and sign on back--->)

Orthodontic : Please check all that apply

The reason(s) for seeking an orthodontic examination is/are:

Dentist referral for general orthodontic evaluation ..... [ ] Yes [ ] No

Dentist referral for interceptive/preventive care ..... [ ] Yes [ ] No

Dentist referral for periodontal health ..... [ ] Yes [ ] No

Dentist referral for pre-restorative care ..... [ ] Yes [ ] No

Self referral for cosmetic improvement ..... [ ] Yes [ ] No

Self referral for improving function ..... [ ] Yes [ ] No

Self referral for improving hygiene ..... [ ] Yes [ ] No

Self referral to prolong lifespan of teeth ..... [ ] Yes [ ] No

Second opinion (other exams pending?) .... [ ] Yes [ ] No

Do the upper teeth stick out too far? (Buck teeth) ..... [ ] Yes [ ] No

Do the lower teeth stick out too far? (Underbite) ..... [ ] Yes [ ] No

Do the upper teeth cover too much of the lower teeth (Deep Bite) ..... [ ] Yes [ ] No

Is there an Open Bite? ..... [ ] Yes [ ] No

Is there a Cross Bite or Scissors Bite? ..... [ ] Yes [ ] No

Are the teeth crowded or overlapped? ..... [ ] Yes [ ] No

Are the teeth excessively spaced? ..... [ ] Yes [ ] No

Do the midlines of both jaws **not** line up? (Dental Asymmetry) ..... [ ] Yes [ ] No

Is there any facial growth problem? ..... [ ] Yes [ ] No

Is there any future dental work dependent on orthodontic care? ..... [ ] Yes [ ] No

Do you feel that bite problems exist that effect the jaw joints? ..... [ ] Yes [ ] No

Are there any problems with chewing, swallowing or speaking? ..... [ ] Yes [ ] No

Are there any habit problems (thumb, finger, or tongue)? ..... [ ] Yes [ ] No

Has there ever been a bite adjustment or splint worn? ..... [ ] Yes [ ] No

Is there any facial change desired? ..... [ ] Yes [ ] No

Does / did any other family member have a similar problem? ..... [ ] Yes [ ] No

Are there concerns that might prevent following through with treatment? [ ] Yes [ ] No

Signature _____ Date _____