For the following questions choose yes, no, or don't know. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

MEDICAL HISTORY

Now or in the past have you had...

YES	NO	DON'T KNOW	
			Birth Defects or hereditary problems?
			Bone fractures, any major accidents?
			Rheumatoid or arthritic conditions?
			Endocrine or thyroid problems?
			Kidney problems?
			Diabetes?
			Cancer, tumor, radiation treatment, or chemotherapy?
			Stomach ulcer or hyperacidity?
			Polio, mononucleosis, tuberculosis, Pneumonia?
			Problems of immune system?
			AIDS or HIV positive?
			Hepatitis, jaundice, or liver problems?
			Fainting spells, seizures, epilepsy, or neurological problems?
			Mental health disturbance or depression?
			Vision hearing, tasting, speech difficulties?
			Loss of weight recently, poor appetite?
			History of eating disorder? (anorexia, bulimia)?
			Excessive bleeding or bruising tendency, anemia or bleeding disorde
			High or low blood pressure?
			Tired easily?
			Chest pain, shortness of breath or swelling of ankles?
			Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?
			Skin Disorders?
			Do you have a well-balanced diet?
			Frequent headaches, colds, or sore throats?
			Eye, ear, nose, or throat condition?
			Hay fever, asthma, sinus trouble, or hives?
			Tonsil or adenoid conditions?
			Osteoporosis?

ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING...

YES	NO	DON'T KNOW

Local anesthetics (Novocain or Lidocaine)
Aspirin
Ibuprofen (Motrin, Advil)
Penicillin or other antibiotics
Sulfa Drugs
Codeine or other narcotics
Metals (jewelry, clothing snaps)
Latex (gloves, balloons)
Vinyl
Acrylic
Animals
Foods (Specify) _____
Other Substances (Specify) _____

Are you currently taking medication, nutrient supplements, herbal medications, or non prescription medicine? Please name them?

Medication	Taken For

YES	NO	DON'T KNOW

Do you currently have or ever had a substance abuse problem?
Do you chew or smoke tobacco?
Operations? _____
Hospitalized? For? _____
Other physical problems or symptoms? _____
Being treated by another health care professional?
For?_____

Date of most recent physical exam?
_____

Do you have any other medical conditions that we should know about?_____
_____

WOMEN ONLY

YES	NO	DON'T KNOW

Are you pregnant?
Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or ever had any of the following...

YES	NO	DON'T KNOW

Bleeding disorders
Diabetes
Arthritis
Severe Allergies
Unusual Dental Problems
Jaw Size Imbalance
Any other family medical conditions we should know about?_____
_____

DENTAL HISTORY

Now, or in the past, has the patient had:

YES	NO	DON'T KNOW

Date of Last Dental Cleaning _____
Permanent or "extra" teeth removed?
Extra or congenitally missing teeth?
Chipped or otherwise injured primary(baby) or permanent teeth
Teeth sensitive to hot or cold; teeth throb or ache?
Jaw fractures, cysts, or mouth infections
"Dead" teeth, or root canals treated?
Periodontal gum problems?
Food impaction between teeth?
Gum boils, frequent canker sores or cold sores?
Thumb, finger, or sucking habit? Until what age?_____
Abnormal swallowing habit (tongue thrusting)?
History of speech problems?

Mouth breathing habit, snoring, or difficulty breathing?
Tooth grinding or jaw clenching?
Any pain, clicking, or locking in jaw or ringing in ears?

Any pain, or soreness in the muscles of the face or around the ears?

DENTAL HISTORY(CONTINUED)

YES	NO	DON'T KNOW

Difficulty in chewing or jaw opening?
Have you ever been treated for "TMD" or "TMJ" problems?
Aware of loose, broken, or missing restorations (fillings)?
Any teeth irritating cheek, lip, tongue, or palate?
Concerned about spaced, crooked, or protruding teeth?
Aware or concerned about under or over developed jaw?
Any relative with similar tooth or jaw relationships?
Any wisdom tooth problems?
Had periodontal (gum) treatment?
Had any serious trouble associated with any previous dental treatme
Been under another dentist's care? Specialist? Other_____
Ever had a prior orthodontic examination or treatment?

Would you object to wearing orthodontic appliances (braces) should they be indicated?