

Medical History

Name and phone number of physician: _____

- | | | | |
|--------------------------|--------------------------|--|-------|
| Yes | No | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in good general health at this time? If not, please explain: | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic or sensitive to any drugs/ medications? If so, please list: | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an accident involving head or facial injury? | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now taking any medication? If so, please list: | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now under medical treatment? If so, please explain: | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever taken Phen-fen (also known as Redux or Pondimin)? If so, when: | _____ |

Have you ever had any of the following?

Yes	No	Yes	No	Yes	No	Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pains	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Any Type)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nerve/Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Herpes (Any Type)	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Ear Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Infection
<input type="checkbox"/>	<input type="checkbox"/>	Blood Vessel Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Glands
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Persistent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Any hospital stays
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to latex/metals	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to Plastic	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Any operations	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints Valves	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery			
<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disability	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Shingles			
<input type="checkbox"/>	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems			

Dental History

Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had or been evaluated for orthodontic treatment?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you had orthodontic treatment before?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you ever clench or grind your teeth?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had gum problems or treatment before?			
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to hot, cold, or sweets?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had serious/difficult problems associated with any previous dental work?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you like your smile?			
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had injury to your: (Please circle):	Mouth	Teeth	Chin
<input type="checkbox"/>	<input type="checkbox"/>	Do you have speech problems?			
<input type="checkbox"/>	<input type="checkbox"/>	Do you have habits (Finger, Thumb, etc.)? If so, please explain: _____			
<input type="checkbox"/>	<input type="checkbox"/>	Do you now or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) If so, Please explain: _____			
<input type="checkbox"/>	<input type="checkbox"/>	Do you generally breathe through your mouth? _____	If yes, please circle:	While Awake?	While Asleep?

I hereby consent to the initial examination. I understand that the taking of diagnostic radiographs (x-rays), photographs and molds will be necessary if treatment is accepted. This office reserves the right to verify credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

Signature of patient _____

Date _____

I verbally reviewed the medical/dental information above with patient named herein.

Comments: _____

Doctor's Signature _____

Date _____