



Patient Health History Form

Patient Name

Date

- Do you need a referral to a dentist? yes no
- Have you ever consulted another orthodontist? yes no
- Is there any dental work that needs to be completed? yes no
- Is the patient currently under a physician's care? yes no

Please explain: _____

What concerns you most about your teeth?

Please explain: _____

Are antibiotics necessary before teeth cleaning?

Please explain: _____

Please list any medications the patient currently takes:

Please list any allergies the patient may have:

HAS THE PATIENT EVER HAD:

- | | | | |
|-------------------------------|--|-----------------------------------|--|
| Kidney Disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Frequent Colds/Sore Throat | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Liver Disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Anemia | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heart Problems | <input type="checkbox"/> yes <input type="checkbox"/> no | Ear Infections | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no | Arthritis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Sinus Problems | <input type="checkbox"/> yes <input type="checkbox"/> no | Disabilities | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Pregnant (Presently) | <input type="checkbox"/> yes <input type="checkbox"/> no | Tonsils/Adenoid Problems | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Heart Murmur/MVP | <input type="checkbox"/> yes <input type="checkbox"/> no | Nervous Disorders | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Latex Allergy | <input type="checkbox"/> yes <input type="checkbox"/> no | Headaches | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Painful Joints | <input type="checkbox"/> yes <input type="checkbox"/> no | Thyroid Problems | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Plastic/Metal Allergy | <input type="checkbox"/> yes <input type="checkbox"/> no | High Blood Pressure | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Fainting or Dizziness | <input type="checkbox"/> yes <input type="checkbox"/> no | Finger/Thumb Sucking | <input type="checkbox"/> yes <input type="checkbox"/> no |
| AIDS/HIV Positive | <input type="checkbox"/> yes <input type="checkbox"/> no | Lip/Tongue Biting | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hepatitis | <input type="checkbox"/> yes <input type="checkbox"/> no | Clenching or Grinding | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Sexually Trans. Disease | <input type="checkbox"/> yes <input type="checkbox"/> no | Jaw Clicking or Popping | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Smoke/Chew Tobacco | <input type="checkbox"/> yes <input type="checkbox"/> no | Cold Sores/Herpes | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Epilepsy/Convulsions/Seizures | <input type="checkbox"/> yes <input type="checkbox"/> no | Mouth Breathing | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bone Disorders | <input type="checkbox"/> yes <input type="checkbox"/> no | Dental Pain | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cancer or Tumor | <input type="checkbox"/> yes <input type="checkbox"/> no | Cavities (Presently) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hemophilia/Prolonged Bleeding | <input type="checkbox"/> yes <input type="checkbox"/> no | Injury to Face, Mouth, Jaw, Teeth | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bruise or Bleed Easily | <input type="checkbox"/> yes <input type="checkbox"/> no | Tongue Thrust | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Tuberculosis/Positive PPD | <input type="checkbox"/> yes <input type="checkbox"/> no | Speech Problems | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Asthma or Hay Fever | <input type="checkbox"/> yes <input type="checkbox"/> no | Missing Permanent Teeth | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Alcoholism/Drug Addiction | <input type="checkbox"/> yes <input type="checkbox"/> no | Extra Permanent Teeth | <input type="checkbox"/> yes <input type="checkbox"/> no |

PLEASE EXPLAIN ANY MEDICAL OR DENTAL PROBLEMS THAT THE PATIENT HAS HAD:

AFFIRMATION

I affirm that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office immediately of any change in medical status or contact information. I understand that where appropriate, credit reports may be attained.

Patient/Parent/Legal Guardian

Date