# HEALTH HISTORY FORM

Patient Name: Date of Birth:

## GENERAL

**Do you need a referral to a dentist?** ☐ yes ☐ no
**Have you ever consulted another orthodontist?** ☐ yes ☐ no If so, when? _____
**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 are the patient's primary concerns regarding their teeth?**

Please explain:_____

**Are antibiotics necessary before teeth cleaning?**

Please explain:_____

| PLEASE LIST CURRENT MEDICATIONS TAKEN BY PATIENT | PLEASE LIST ANY ALLERGIES THE PATIENT MAY HAVE |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## DENTAL HISTORY

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|---|---|---|---|---|---|
| Cavities (Presently) | ☐ yes | ☐ no | Jaw Clicking or Popping | ☐ yes | ☐ no |
| Clenching or Grinding | ☐ yes | ☐ no | Lip/Tongue Biting | ☐ yes | ☐ no |
| Cold Sores/Herpes | ☐ yes | ☐ no | Missing Permanent Teeth | ☐ yes | ☐ no |
| Dental Pain | ☐ yes | ☐ no | Mouth Breathing | ☐ yes | ☐ no |
| Extra Permanent Teeth | ☐ yes | ☐ no | Speech Problems | ☐ yes | ☐ no |
| Finger/Thumb Sucking | ☐ yes | ☐ no | Tongue Thrust | ☐ yes | ☐ no |
| Injury to Face, Mouth, Jaw, Teeth | ☐ yes | ☐ no | | | |

**PLEASE EXPLAIN ANY <u>DENTAL</u> PROBLEMS THAT THE PATIENT HAS HAD:**

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## MEDICAL HISTORY

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|---|---|---|---|---|---|
| AIDS/HIV Positive | ☐ yes | ☐ no | Heart Problems | ☐ yes | ☐ no |
| Alcoholism/Drug Addiction | ☐ yes | ☐ no | Hemophilia/Prolonged Bleeding | ☐ yes | ☐ no |
| Anemia | ☐ yes | ☐ no | Hepatitis | ☐ yes | ☐ no |
| Arthritis | ☐ yes | ☐ no | High Blood Pressure | ☐ yes | ☐ no |
| Asthma or Hay Fever | ☐ yes | ☐ no | Kidney Disease | ☐ yes | ☐ no |
| Bone Disorders | ☐ yes | ☐ no | Latex Allergy | ☐ yes | ☐ no |
| Bruise or Bleed Easily | ☐ yes | ☐ no | Liver Disease | ☐ yes | ☐ no |
| Cancer or Tumor | ☐ yes | ☐ no | Nervous Disorders | ☐ yes | ☐ no |
| Diabetes | ☐ yes | ☐ no | Painful Joints | ☐ yes | ☐ no |
| Disabilities | ☐ yes | ☐ no | Plastic/Metal Allergy | ☐ yes | ☐ no |
| Ear Infections | ☐ yes | ☐ no | Pregnant (Presently) | ☐ yes | ☐ no |
| Epilepsy/Convulsions/Seizures | ☐ yes | ☐ no | Sinus Problems | ☐ yes | ☐ no |
| Fainting or Dizziness | ☐ yes | ☐ no | Smoke/Chew Tobacco | ☐ yes | ☐ no |
| Frequent Colds/Sore Throat | ☐ yes | ☐ no | Thyroid Problems | ☐ yes | ☐ no |
| Headaches | ☐ yes | ☐ no | Tonsils/Adenoid Problems | ☐ yes | ☐ no |
| Heart Murmur/MVP | ☐ yes | ☐ no | Tuberculosis/Positive PPD | ☐ yes | ☐ no |

**PLEASE EXPLAIN ANY <u>MEDICAL</u> PROBLEMS THAT THE PATIENT HAS HAD:**

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_____

## 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.

_____ _____ _____

Patient/Parent/Legal Guardian Name | Patient/Parent/Legal Guardian Signature | Date