

HEALTH HISTORY

PATIENT NAME: _____

Has an orthodontist been consulted previously? Yes No
Is the patient having jaw pain or discomfort at this time? Yes No
Does the patient feel very nervous about having ortho treatment? Yes No
Is the patient taking any medications, drugs or pills? Yes No

If yes, reason: _____

Are you aware of being allergic to or have you ever reacted adversely to any medication or substances (Such as latex or any metals) Yes No

If yes, please list: _____

Does the patient require medication prior to dental procedures? Yes No

What are the patient's or parent's primary concerns regarding his or her smile?

Indicate which of the following the patient has had or has present.

Circle Yes or No

Adenoids Removed	Yes	No	Cosmetic Surgery	Yes	No	Liver Problems	Yes	No
AIDS/HIV	Yes	No	Diabetes	Yes	No	Kidney Problems	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Mental Health Issue	Yes	No
Anorexia/Bulimia	Yes	No	Endocrine Disorders	Yes	No	Mononucleosis	Yes	No
Arthritis	Yes	No	Epilepsy or Seizures	Yes	No	Nervousness	Yes	No
Asthma	Yes	No	Fainting or Dizziness	Yes	No	Pneumonia	Yes	No
ADD	Yes	No	Hearing Loss	Yes	No	Pregnant	Yes	No
Birth Defect	Yes	No	Heart Pacemaker/	Yes	No	Rheumatic Fever	Yes	No
Hereditary Problems	Yes	No	Surgery	Yes	No	Rheumatism	Yes	No
Blood Transfusion	Yes	No	Heart Trouble	Yes	No	Scarlet Fever	Yes	No
Bruise Easily	Yes	No	Hemophilia	Yes	No	Sickle Cell Disease	Yes	No
Chemotherapy	Yes	No	Hepatitis A	Yes	No	Sinus Trouble	Yes	No
Cold Sores	Yes	No	Hepatitis B	Yes	No	Skin Disorder	Yes	No
Cortisone Medicine	Yes	No	Immune Disorder	Yes	No	Stroke	Yes	No

Additional comments or any other information that you can share that will aid us in treating the patient?

Is the patient on a special diet? Yes No

If yes, what? _____

Does the patient have any disease, condition or problem not listed? Yes No

If yes, what? _____

Have there been any injuries to the face, mouth, or teeth Yes No

If yes, what? _____

Has the patient ever sucked a thumb or finger? Yes No

If yes, are they still? _____

Does the patient have any speech problems? Yes No

If yes, what? _____

Is the patient a mouth breather? While awake? Yes No While asleep? Yes No

Has the patient ever been informed of any missing or extra permanent teeth? Yes No

If yes, which ones? _____

I have read and understand the proceeding questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT:

The undersigned hereby authorizes Dr. Williams to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Williams to make thorough diagnosis of the patient's dental needs. I also authorize Dr. Williams to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that Dr. Williams choose to employ such assistance as deemed fit.

Signature (Parent's signature if minor) _____