

Medical History

Is patient in good health? Yes No

Does patient have any history of illness? Yes No

If yes, please briefly describe: _____

Please circle any of the following that the patient was treated for:

Diabetes	Tuberculosis	Endocrine Problems	Prolonged Bleeding
Pneumonia	Anemia	Heart Trouble	Epilepsy
Dizziness	Nervous Disorders	Bone Disorders	Kidney Disorders
Rheumatic Fever	Asthma	Nasal Blockage	Liver Disorders

Does patient have tendency toward: colds sore throats ear infections headaches

Has patient ever been exposed to: herpes aids hepatitis

Have tonsils and/or adenoids been removed? Yes No

List drugs or medication being taken: _____

List any allergies or drug sensitivities: _____

Dental History

Does patient want teeth straightened? Yes No

Does patient have speech problems? Yes No

Has patient ever sucked a thumb or a finger? Yes No if yes, until what age? _____

Does patient breathe through the mouth while awake? Yes No or while asleep? Yes No

Has patient been informed of any missing teeth? Yes No any extra teeth? Yes No

Does patient have popping jaw or pain in jaw? Yes No frequent headaches? Yes No

Has patient had injuries to the face or jaw? Yes No clench or grind teeth? Yes No

Family History

Please list the children in your family and indicate if they had had orthodontic treatment.

Name	Birthday	Age	Orthodontics
_____	_____/_____/_____	_____	Yes / No
_____	_____/_____/_____	_____	Yes / No
_____	_____/_____/_____	_____	Yes / No
_____	_____/_____/_____	_____	Yes / No

If any person above has received orthodontic treatment, please describe.

Has either parent had orthodontic treatment? Yes / No If so, which one? _____

Please describe briefly any special aspects of the treatment. _____

Are you aware that some appointments will infringe on school time? Yes / No

Please give a brief description of the reasons for your visit. _____

Have you previously consulted an orthodontist? Yes / No

Responsible Party's Signature: _____