

Medical and Dental History

Patient's Name _____ BirthDate _____

	Yes	No
Are you in good health?		
Do you have a history of major illness? If yes, please explain:		
Other than for check-ups, have you ever been under a physician's care? If yes, please explain:		
Have you ever tested positive for hepatitis or HIV?		
Have you ever been hospitalized? If yes, please explain:		
Have you ever needed to take antibiotics prior to dental procedures?		
Are you allergic to latex or nickel?		
Do you have any allergies or drug sensitivities? If yes, please list:		
Are you currently taking any medication(s)? If yes, please list medication(s) and reason(s) for use:		
Have you ever sustained trauma to your face, mouth, or teeth?		
Do you have any head, face, mouth or jaw pain?		
Do you clench or grind your teeth?		
Do you ever experience jaw pain or notice jaw noises (e.g. clicking or popping) when chewing or yawning?		
Are you currently undergoing or planning to have dental treatment (e.g. caps, fillings, periodontal surgery, implants)?		
Have you ever been treated for periodontal disease?		
Have you ever sucked your thumb or finger? If yes, until what age?		
Have you ever been examined or treated by another orthodontist?		
WOMEN ONLY:		
Are you pregnant?		
Are you trying to get pregnant?		
Are you taking any medication for osteoporosis or osteopenia (e.g. Fosamax, Boniva)		

Patient's Signature

Date