

MEDICAL HISTORY

Family Physician _____ City _____

Has the patient ever had or presently have: (Circle those that apply)

- | | | | |
|---------------|--------------------|---------------------|------------------------|
| AIDS | Bone Disorders | Emotional Problems | Hepatitis |
| Asthma | Diabetes | Heart Disease | Rheumatic Fever |
| Anemia | Epilepsy | Hearing Disorder | Herpes |
| Blood Disease | Endocrine Problems | Head or Face Injury | Other (Describe Below) |

Does the Patient:

Have allergies to:	Seasonal Grasses _____	Food _____	Drugs _____	Other _____
Breath through mouth	no	yes	sometimes	
Tonsils removed	no	yes	when?	
Adenoids removed	no	yes	when?	
Thumbsucker	no	yes		

Present drugs or medication/reason: _____

Has patient been under the care of a physician during the past two years, other than routine examination (Physical & Mental)?
no yes (if yes, please describe below)

DENTAL AND JAW (TMJ) JOINT HISTORY

Has the patient had any serious injuries or blows to the mouth? yes no Treatment? yes no (describe)

Does the patient experience any:

Pain or limitation of movement of the lower jaw? (Chewing Difficulty)	yes	no
Any popping, cracking, or grinding noises when the jaw is opened or closed	yes	no
Frequent head or neck aches	yes	no
Pain or ringing in the ears	yes	no

Does the patient clinch or grind the teeth?	yes	no
Has your jaw ever locked or slipped out of place?	yes	no
Do you have any speech problems?	yes	no

ORTHODONTIC INFORMATION

Who noticed your orthodontic problem first? self dentist Friend other _____

In your own words describe your problem: _____

Has the patient had previous orthodontic consultation?	yes	no
Treatment?	yes	no
Date _____ Doctor _____		

Have you been informed of any missing or extra permanent teeth? yes no

What is the patients attitude toward wearing "braces"?

- a.) excited
- b.) complacent / resigned
- c.) antagonistic / unwilling

Has any other member of the family had orthodontic treatment? yes no

Is patient interested in having treatment for:

- | | | |
|----------------------|------------------------------|---|
| a.) appearance | c.) better speech | e.) reduction in jaw or face discomfort |
| b.) better digestion | d.) better bite relationship | f.) preventing gum problems |

Our office policy is that the parent who requests treatment for the child is responsible for all fees for services rendered. I understand that where appropriate, credit bureau reports may be obtained.

This form was completed by (parent's signature if minor) _____