Health & Dental History

Today's Date:

Name: *(Last, First, Middle)* ☐ M ☐ F	**DOB:**
Referring Dentist:	**Date of last Dental exam:**
Previous Orthodontic consultation: (Y or N)	**Height:** **Weight:**
Family Physician name & phone number:	**Mouth breather: (awake, asleep or both)**

PERSONAL HEALTH HISTORY

Illnesses/procedures performed (mark all that apply):

□ Measles	□ Mumps	□ Pneumonia	□ Speech problems	□ Tonsils removed
□ Rubella	□ Chickenpox	□ Hepatitis A/ B/ C	□ Bleeding problems	□ Adenoids removed
□ Heart Condition	□ Rheumatic Fever	□ Epilepsy	□ Scarlet fever	□ Frequent colds
□ Diabetes	□ Polio	□ Asthma	□ Whooping cough	□ STD's
□ Anemia	□ Nervous condition	□ Tuberculosis	□ Kidney problems	□ Herpes
□ Problems chewing	□ Problems swallowing	□ Breathing problems	□ Fainting	□ HIV/AIDS

Immunizations and dates:

☐ Tetanus	☐ Pneumonia
☐ Hepatitis	☐ Chickenpox
☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

Any discomfort when opening or closing mouth?

Are teeth brushed daily? How many times per day? **Is floss used?**

Positions while sleeping? (Side/back/face down/all)

Any past facial or mouth injuries?

Do you play any musical wind instrument?

Age of first erupted baby tooth? **Permanent tooth?**

List any medical or dental problems that other Doctors or Dentists have diagnosed

Surgeries & other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

Tongue Thrust: □ Frontal □ Lateral
Lip: □ Wedging □ Biting
Grinding: □ Awake □ Asleep □ Both
Posture: (Leaning on) □ Cheek □ Chin □ Nose □ Forehead

Sucking: □ Fingers □ Thumb □ Blanket □ Pacifier □ Cheek
Biting: □ Nails □ Pencils/Pens □ Other objects
Swallowing: □ Lips pursed □ Head nodding □ Unusual effort
Other observations:

Extractions needed:_____

Fixed or removable treatment needed_____

Phase I treatment fee:_____

Phase II treatment fee:_____

Complete treatment fee:_____