Medical History

Do you:

Have allergies? Yes____ No ____ If yes, what type? _____

Have any conditions that affect the immune system (AIDS, HIV, Leukemia)?	Y	N
Bruise easily after injury?	Y	N
Experience prolonged bleeding after injury?	Y	N

Have you ever had:

Surgery with general anesthetic	Y	N	If yes, what type? _____		
Rheumatic fever	Y	N	Diabetes	Y	N
Chronic kidney problems	Y	N	Heart problems	Y	N
Lung problems	Y	N	Liver problems	Y	N
Epilepsy	Y	N	Cerebral palsy	Y	N
Abnormal bleeding problems	Y	N	Prosthetic joint	Y	N
Bronchitis	Y	N	Head/ear aches	Y	N

Please list any medications used regulary: _____

Any other medical information/dental-related concerns you would like us to know about? _____
_____

Dental History

What are the main concerns regarding your teeth? _____
_____

Who is the family dentist? _____

How did you hear about our office? (Dentist referral? Friend? Internet Search?)_____

Do you:

Want orthodontic treatment?	Y	N			
See your general dentist regularly?	Y	N	Last visit: _____		
Smoke or chew tobacco?	Y	N			
Grind your teeth at night?	Y	N	If yes, do you wear a mouthguard?	Y	N

Have you:

Ever had previous orthodontic consultations/treatment?	Y	N	
Ever had problems with sore gums?	Y	N	
Ever seen a periodontist regarding gum health?	Y	N	Last visit: _____
Ever received a severe blow to the teeth or jaws?	Y	N	

I, _____ , give permission to allow Dr. Dueckman and Dr. Felty (and/or staff) to report any findings to my dentist or any other dental professional as he deems necessary.

Signature:_____ Date:_____