Medical History

Does the patient:

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

Has the patient 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 regularly: _____

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

Dental History

What are the main concerns regarding the patient's teeth? _____
_____

Who is the family dentist? _____

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

Does the patient:

Want orthodontic treatment?	Y	N	
Brush his/her teeth daily?	Y	N	How often: _____
See a general dentist regularly?	Y	N	Last visit: _____
Play a musical instrument?	Y	N	What type: _____

Have any of the following habits?

Thumb sucking	Y	N
Grinding teeth at night	Y	N
Nail biting	Y	N
Mouth breathing (eg. mouth open when reading/watching TV)	Y	N

Has the patient:

Ever had previous orthodontic consultations/treatment?	Y	N	
Ever had problems with sore gums?	Y	N	
Ever received a severe blow to the teeth or jaws?	Y	N	
Ever had speech therapy?	Y	N	If yes, how old was the patient? _____

I, _____ ([Circle one]: Mother, Father, Patient, Guardian), 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:_____