

# HEALTH HISTORY

( Please complete Both Sides before exam appointment and bring with you )

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Phone \_\_\_\_\_ Emerg Contact \_\_\_\_\_

Family Physician \_\_\_\_\_ General Dentist \_\_\_\_\_

## Significant Medical History and current problems:

- Birth Defect or trauma \_\_\_\_\_
- Motor Vehicle Accident \_\_\_\_\_
- Facial Injury \_\_\_\_\_
- Major Illness or Surgery \_\_\_\_\_
- Contact with AIDS, Hepatitis, or Tuberculosis \_\_\_\_\_
- Current problem requiring medical care \_\_\_\_\_

## Please circle all that may apply :

Anemia, Arthritis, Asthma, Bone Disorders, Diabetes, Dizziness, Endocrine Disorders, Epilepsy, Fainting, Growth Problems, Heart Problems, High or Low Blood Pressure, Kidney Problems, Liver Problems, Nervous Problems, Rheumatic Fever, Scarlet Fever

Please Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General Health : \_\_\_\_\_

Breathing Problems / Allergies : \_\_\_\_\_

Medications : \_\_\_\_\_

Frequency of use of Aspirin/Tylenol/Motrin/etc .....[ ] Daily.....[ ] Weekly.....[ ] Seldom

## Dental - Has there ever been any:

- |                                                                      |                              |                             |
|----------------------------------------------------------------------|------------------------------|-----------------------------|
| Pain in either jaw joint?.....                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Injury to the face mouth, teeth or jaws? .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Clicking, popping, locking, or dislocation of either jaw joint?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Limitation of jaw movement or function? .....                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Inability to breathe comfortably with the lips closed? .....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Jaw soreness or headaches with function? .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Permanent teeth removed? .....                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Orthodontic care prior to this time? .....                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Finger or thumb habit or tongue problem? .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problem with sore or bleeding gums or Periodontal care? .....        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of grinding or clenching the teeth / jaws? .....             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Missing or extra teeth? .....                                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please Explain: \_\_\_\_\_  
\_\_\_\_\_

( Please complete Both Sides and sign on back---> )

**Orthodontic :** Please check all that apply

The reason(s) for seeking an orthodontic examination is/are:

- Dentist referral for general orthodontic evaluation .....  Yes  No
- Dentist referral for interceptive/preventive care .....  Yes  No
- Dentist referral for periodontal health .....  Yes  No
- Dentist referral for pre-restorative care .....  Yes  No
- Self referral for cosmetic improvement .....  Yes  No
- Self referral for improving function .....  Yes  No
- Self referral for improving hygiene .....  Yes  No
- Self referral to prolong lifespan of teeth .....  Yes  No
- Second opinion (other exams pending?) .....  Yes  No
- Do the upper teeth stick out too far? (Buck teeth) .....  Yes  No
- Do the lower teeth stick out too far? (Underbite) .....  Yes  No
- Do the upper teeth cover too much of the lower teeth (Deep Bite) .....  Yes  No
- Is there an Open Bite? .....  Yes  No
- Is there a Cross Bite or Scissors Bite? .....  Yes  No
- Are the teeth crowded or overlapped? .....  Yes  No
- Are the teeth excessively spaced? .....  Yes  No
- Do the midlines of both jaws **not** line up? (Dental Asymmetry) .....  Yes  No
- Is there any facial growth problem? .....  Yes  No
- Is there any future dental work dependent on orthodontic care? .....  Yes  No
- Do you feel that bite problems exist that effect the jaw joints? .....  Yes  No
- Are there any problems with chewing, swallowing or speaking? .....  Yes  No
- Are there any habit problems (thumb, finger, or tongue)? .....  Yes  No
- Has there ever been a bite adjustment or splint worn? .....  Yes  No
- Is there any facial change desired? .....  Yes  No
- Does / did any other family member have a similar problem? .....  Yes  No
- Are there concerns that might prevent following through with treatment?  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_