

In your own words, what is the chief orthodontic concern? _____

What would you like orthodontic treatment to accomplish? _____

MEDICAL INFORMATION

Is there a patient history of:

- Frequent or severe headaches yes no
- Heart Disease yes no
- Sinus or respiratory disease yes no
- Blood disease yes no
- Liver disease yes no
- Thyroid disease yes no
- Kidney disease yes no
- H.I.V. positive yes no
- Venereal disease yes no
- Intestinal disease yes no
- Bone disease yes no
- Nervous/emotional problems yes no
- High or Low blood pressure yes no
- Endocrine problems yes no
- Problems with wounds healing yes no
- Tumors or Cancer yes no
- Tonsillitis / Sore throats often yes no
- Joint problems yes no
- Rheumatic/yellow/scarlet fever yes no
- Acquired Immune Deficiency Syndrome yes no
- Is patient under medical care? yes no
- Is patient pregnant at this time? yes no
- Measles/mumps/chicken pox yes no
- Does patient smoke yes no
- Fever Blisters yes no
- Height and weight normal for age yes no
- Is patient in good health? yes no
- Has patient has a physical this year? yes no
- Has patient reached puberty? yes no
- If male, has patient begun to shave? yes no
- If female, has patient begun menstruation? yes no
- Anemia yes no
- Hemophilia yes no
- Emphysema yes no

- Heart Murmur yes no
- Polio yes no
- Diabetic yes no
- Epileptic yes no
- Asthma/hay fever yes no
- Tuberculosis yes no
- Broken bones yes no
- Rheumatism/arthritis yes no
- Is patient taking medicine? yes no
- Fainting/dizziness yes no
- Drug addiction yes no
- Yellow jaundice yes no
- Radiation therapy yes no
- Chemical therapy yes no
- Blood transfusions yes no
- Hepatitis
 - Hepatitis A yes no
 - Hepatitis B yes no
 - Hepatitis C yes no

other, please specify: _____

Any allergies or unusual reactions to

- Aspirin yes no
- Barbiturates yes no
- Sulfa drugs yes no
- Penicillin yes no
- Latex yes no

Other: _____

List any other allergies or reactions: _____

List any medications currently taking: _____

Are you aware of any other disease condition or problem not listed above that we should know about? _____

Authorization

I understand that, where appropriate, credit bureau reports may be obtained.

Patient / Parent Signature: _____

Date: _____

Doctor Signature: _____

Date: _____