Patient Name____ Age__________________

Medical History

Are you or have you ever been diagnosed or treated with any of the following conditions:

	Yes	No	Unknown
Endocrine/Thyroid Problems			
Diabetes			
Kidney Disease			
Bone Disorder			
Arthritis			
Epilepsy/Faint Spells/Seizures/Neurological Disorders			
Blood Disorder			
Fainting			
Heart Disease/Cardiovascular Disorder			
Hepatitis			
Emotional Disorder			
Mental Health/Behavioral Disorder			
Vision/Hearing/Tasting/Speech Difficulties			
Birth Defects/ Hereditary Disorders			
Cancer/Tumor/Radiation Treatment or Chemotherapy			
Immune System Problems			
High/Low Blood Pressure			
Eye/Ear/Nose/Throat Condition (Tonsil or Adenoid Condition) or Skin Disorder			
Asthma or Sinus Troubles			
Bone Fractures or Any Other Major Accidents			
History of Eating Disorder (Anorexia/Bulimia)			
Excessive Bruising/Bleeding Disorder (Hemophilia) or Tendency, Anemia			
Does patient eat a well-balanced diet?			
Polio/Mononucleosis/Tuberculosis or Pneumonia			
Frequent Headaches, Colds or Sore Throats			
Stomach Ulcer or Hyperacidity			
Tires Easily, Chest Pain, Shortness of Breath, Swelling Ankles			
Loss of weight recently, poor appetite			
Chew or Smoke Tobacco			
AIDS or HIV Positive			
Are you pregnant?			

Do you have **allergies** or adverse reactions to any of the following:

	Yes	No	Unknown
Local Anesthetic (Novocaine, Lidocaine)			
Latex			
Asprin			
Ibuprofen (Motrin, Advil)			
Penicillin			
Other Antibiotics			
Sulfa drugs			
Codeine or other narcotics			
Acrylics			
Plant Pollens			
Animals			
Foods			
Metals			
Vinyl			
other			

If you answered yes to any of the above, please specify:
____
____
____
____
____
____
____

Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers: such as Zomata (zolendronic acid), Aredia (panidronate), Didronel (etidronate)?
Please circle: Yes No Unknown

Are you currently taking or have you taken any oral bisphosphonates for osteoporosis, osteopenia, or other uses: such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate)?
Please circle: Yes No Unknown

Is the patient taking medication, nutritional supplements, herbal medications or non-prescription medicine?
Please circle: Yes No Unknown
Please list if yes is circled:
____
____
____

Please continue to reverse page

Name of Primary Care Physician ______________________________
Are you under doctor's care for any reason other than wellness? If yes, please describe. ______________________________
____
Please describe any past or present medical problems, hospitalizations and operations ______________________________
____
____
Do you consider yourself in good health? ______________________________
Please list any medications you are currently taking: ______________________________
____
____
Are there any medical concerns you have that we should be aware of? If yes, please describe:
____
____

Dental History

Now or in the past, have you ever had:

	Yes	No	Unknown
Supernumerary (extra) teeth			
Congenitally missing teeth			
Chipped or injured primary or permanent tooth			
Sensitive or sore teeth			
Jaw fractures, cysts or infections			
Frequent canker or cold sores			
Speech problems			
Thumb/Finger sucking Habit or Tongue Thrusting			
Mouth breathing habit, snoring, or difficulty breathing			
"Dead teeth" or root canals treated			

	Yes	No	Unknown
Tooth grinding or clenching			
Clicking or locking in jaw			
Soreness in jaw or face muscles			
TMD or TMJ			
Serious trouble associated with previous dental treatment			
Gum disease (periodontitis/gingivitis)			
Are you taking any forms of fluoride?			
Concerned about spaced, crooked, protruding teeth, over or underdeveloped jaw, or teeth causing any irritation to cheek/lip/tongue/palate			
Any serious trouble associated w/ previous dental treatment?			

Name of General Dentist ______________________________
____
Do you receive regular general dental care?
____
What is the date of your last dental visit?
____
Have you had previous orthodontic treatment or consultations for treatment?
____
____
Why are you seeking orthodontic treatment?
____
____
____
Are there any other dental conditions or issues we should be aware of? If yes, please describe.
____
____
____

______________________________ ______________
Signature of patient or parent/ legal guardian **Date**

______________________________ ______________
Medical history update **Date**

______________________________ ______________
Medical history update **Date**

______________________________ ______________
Medical history update **Date**