MEDICAL HISTORY

Patient Name______________________________

Physician ____Date of Last Visit ______________________________
Address____Phone ____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? If yes, please list and reason _______________________________________
____
Yes No Are you taking or have you ever taken a Bisphosphonate medication? If yes, how long?_________________
Yes No Are you allergic to any medication? ____
Yes No Are you allergic to latex? ____
Yes No Are you allergic to nickel? ____
Yes No Do you have a history of a major illness? ____
Yes No Have you had any major operations? ____
Yes No Have you ever been involved in a serious accident? ____

Circle yes or no for which the patient has a history:

Y N Abnormal bleeding / Hemophilia	**Y N** Chest pains	**Y N** Hepatitis/Liver problems	**Y N** Pneumonia
Y N Anemia	**Y N** Clicking of jaw	**Y N** Herpes	**Y N** Prolonged Bleeding
Y N Arthritis	**Y N** Cold sores / Herpes	**Y N** High Blood Pressure	**Y N** Pregnant
Y N Asthma	**Y N** Diabetes HIV / Aids	**Y N** Immune problems	**Y N** Rheumatic Fever
Y N Aids	**Y N** Downs Syndrome	**Y N** Kidney problems	**Y N** Radiation / Chemotherapy
Y N Bone Disorders	**Y N** Endocrine problems	**Y N** Low Blood Pressure	**Y N** Tuberculosis
Y N Bulimia	**Y N** Epilepsy	**Y N** Mouth Breathing	**Y N** Scoliosis
Y N Periodontal problems	**Y N** Gastrointestinal problems	**Y N** Muscular Disorders	**Y N** Seizures
Y N Cancer	**Y N** Heart problems	**Y N** Nervous Disorders	**Y N** Speech problems
Y N Congenital Heart Defect	**Y N** Heart Murmur	**Y N** Organ Transplant	**Y N** Smoking/Tobacco

Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________________
____

Blood Pressure______/_______ **Medical History Reviewed By Doctor**_____________ **Date**_____________

DENTAL HISTORY

Dentist____Date of last visit _______________________________
What concerns you most about your teeth? ____

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _________________________________
Yes No Have you ever lost or chipped any teeth? ____
Yes No Have there been any injuries to face, mouth or teeth? ____
Yes No Is any part of your mouth sensitive to temperature or pressure? ___________________________________
Yes No Do your gums bleed when you brush? ____
Yes No Do you have any type of thumb or tongue habit? ____
Yes No Are you a mouth breather? ____
Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________________________
Yes No Has anyone in your family received orthodontic treatment? _______________________________________
How did they feel about the result? ____
What is your attitude toward receiving orthodontic treatment? _________________________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?______________________
Yes No Are you aware of your jaw clicking/popping? ____
Yes No Do you have TMJ or pain in your jaw joints?____
Yes No Are you aware of clenching your teeth during the day? ____
Yes No Have you ever been told that you grind your teeth? ____
Yes No Do you have "tension" headaches?____
Yes No If the patient is under age 16, height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school/work hours? ___________________________
Please list some hobbies or interests ____

Female Patients only:

Yes No Are you pregnant?____
Yes No Has menstruation started? If yes, when? ____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Becher to perform a complete orthodontic evaluation.

Signature: ____**Date**______________________________________

Medical History Update Signature: ______________________________**Date:**_________**Dr Initials:** ________________________
Medical History Update Signature: ______________________________**Date:**_________**Dr Initials:** ________________________