MEDICAL / DENTAL HISTORY

Patients 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? ____

YES NO Are you allergic to any medication? ____

YES NO Do you have a history of a major illness? ____

YES NO Are you currently under a physician's care? ____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding	Diabetes	Hepatitis/Liver problems	Rheumatic Fever
Anemia	Dizziness	Herpes	Tuberculosis
Arthritis	Epilepsy	High Blood Pressure	
Asthma	Heart Murmur	HIV/AIDS	
Congenital Heart Defect	Heart Problems	Kidney problems	

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

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Dentist____ Date of last cleaning ____________

What concerns you most about your teeth? ____

Please circle yes or no

YES NO Have you ever seen an orthodontists? If yes, who and when?_________________________________

YES NO Have your tonsils and adenoids been removed? ____

YES NO Are you allergic to latex? ____

YES NO Are you allergic to nickel? ____

YES NO Do you need antibiotics before seeing the dentist? ____

Please circle any of the dental conditions below that you have had or currently have.

Cold Sores	Jaw/Facial Injuries	Mouth Breathing	Tension Headaches
Clenching/Grinding of teeth	Jaw Clicking/Popping	Ringing in the ears	Thumb Sucking
Dental/Tooth Injuries	Jaw Locking	Smoke/Chew tobacco	Tongue Thrust

Female Patients Only

Are you pregnant? ____

Please circle Yes or No to the following question if you are under 14 years old:

YES NO Has menstruation started?

Are there any dental conditions we have not discussed that you feel we should be aware of? ___________________

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AFFIRMATION

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status I hereby give Dr. Robinson and Team permission to confirm appointments using the phone number(s) or emails I have provided, to include leaving messages. In addition, I authorize Dr. Robinson to perform a complete orthodontic evaluation.

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Patient/Parent/Guardian Signature Date

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Doctor Signature Date