ORTHODONTIC HEALTH HISTORY

Patient's Name ______________________ **Account #**____________

1. Is patient in good health? ☐Yes ☐No
   If No, explain: ____________________

2. Is patient under physician's care now? ☐Yes ☐No
   If Yes, explain: ____________________

3. Is patient taking any medications? ☐Yes ☐No
   If Yes, name of medications: ____________________

4. Is patient taking any substances? ☐Yes ☐No
   If Yes, name of substances: ____________________

5. Has patient taken the prescription drugs fenfluramine, fenfluramine combined with phen-termine (fen-phen), dexfenfluramine (redux), or other weight loss products? ☐Yes ☐No

6. Has patient ever had a blood transfusion? ☐Yes ☐No
   If Yes, explain: ____________________

7. Is patient pregnant or suspect? ☐Yes ☐No
   If Yes, how many months? ____________________

8. Has patient had any illnesses listed below?

AIDS/ARC	☐Y ☐N	Diabetes	☐Y ☐N	Health Problem	☐Y ☐N	Rheumatic Fever	☐Y ☐N
Allergies	☐Y ☐N	Dizzy Spells	☐Y ☐N	Hepatitis	☐Y ☐N	Sinus Trouble	☐Y ☐N
Anemia	☐Y ☐N	Epilepsy	☐Y ☐N	High Blood Press	☐Y ☐N	Tuberculosis	☐Y ☐N
Angina	☐Y ☐N	Fainting	☐Y ☐N	Kidney Disease	☐Y ☐N	Veneral Disease	☐Y ☐N
Asthma	☐Y ☐N	Fever Blisters	☐Y ☐N	Liver Problems	☐Y ☐N	Other: ____________	
Cold Sores	☐Y ☐N	Heart Murmur	☐Y ☐N	Low Blood Press	☐Y ☐N	____________	

9. Has patient ever had a reaction to local anesthetic? ☐Yes ☐No
   If Yes, explain: ____________________

10. Is patient allergic to any medication (like penicillin)? ☐Yes ☐No
    If Yes, explain: ____________________

11. Is patient allergic to metal or latex? ☐Yes ☐No
    If Yes, explain: ____________________

12. Does patient's jaw pop or click when chewing? ☐Yes ☐No

13. Any accidents involving the teeth? ☐Yes ☐No

14. Has Patient had any disease, condition or problem not listed above that we should know about? ☐Yes ☐No
    If Yes, explain: ____________________

Please Check Any Habits:

Nail Biting	☐Yes ☐No	Lip Biting	☐Yes ☐No
Thumb Sucking	☐Yes ☐No	Night Grinding	☐Yes ☐No
Pencil Biting	☐Yes ☐No	Mouth Breathing	☐Yes ☐No

Other Habits: ____________________

Name of Patient's Dentist ____________________ **Last Dental Checkup** ____________________

Emergency Contact ____________________ **Home Phone (___)** __________ **Work Phone (___)**__________

Print Name ____________________ **Signature** ____________________
Patient (Parent or Guardian, if Minor) Patient (Parent or Guardian, if Minor)

Health History Reviewed By: ____________________ **Date:** ____________________
(Orthodontist Signature)

Review 6 Months By: ____________________ Review 12 Months By: ____________________
Patient's Signature Patient's Signature

Review 18 Months By: ____________________ Review 24 Months By: ____________________
Patient's Signature Patient's Signature