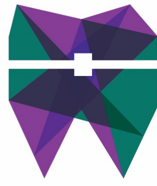

Page 2: New Patient Health History Form

Printed Full Name: ____

Medical Information:
General Doctor's Name ___________________________________ Phone number_________________
Address _________________________________ City: ___________________ State _______________

Patient's Medical History:
Are you generally in good health? Yes __________ No __________
Do you have any history of major illness? Yes __________ No __________
If so, please list: ____
Are you presently under the care of a physician? Yes __________ No __________
If yes, please indicate the condition being treated:____

Check the following for which you have been treated:
HIV/AIDS related condition __ Anemia __ Asthma __ Cancer __ Diabetes __
Epilepsy __ Fainting or Dizziness __ Glaucoma __ Heart Trouble __ Nervousness __
Osteoporosis __ Pneumonia __ Prolonged Bleeding __ Rheumatic Fever __ Tuberculosis __
Other __
List any allergies or drug sensitivities: ____
List any drugs now being taken:____
Have you/are you currently taking Bisphosphonate (Fosamax, Actonel, Boniva)? Yes __ No __
Have your tonsils and/or adenoids been removed? Yes __ No __ If so, at what age? _____

Patient's Dental History:
Have you had any injuries to the face, mouth or teeth? Yes __ No __
If so, please explain ____
Does your jaw click or lock? Yes __ No __ If so, is it painful? Yes __ No __
Have you ever been treated for or informed of an incorrect swallowing pattern/habit? Yes __ No __
Do you have any speech problems? Yes __ No __
Are you a mouth breather? Yes __ No __ While awake? Yes __ No __ While asleep? Yes __ No __
Have you ever been informed of any missing or extra teeth? Yes __ No __
Have you ever had any adult teeth removed? Yes __ No __
Have you ever undergone any orthodontic treatment? Yes __ No __
Has another orthodontist been consulted about your present condition? Yes __ No __
Has any member of your family undergone orthodontic treatment? Yes __ No __
Please list anything else of concern to you:

____
Signature: ____ Date: _________________