SHANNON HILGERS NISSEN
ORTHODONTICS

**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: _____