MEDICAL AND DENTAL HISTORY

Your answers to the following questions will be helpful in better understanding the patient and determining an appropriate plan of treatment.

Patient's Name: _____ Today's Date: _____

This form completed by: _____

Name of Dentist: _____

Approximate date of last dental check-up: _____

Is the patient under a physician's care? _____

Name of physician: _____

What drugs or medication is the patient taking? _____

Present general health: excellent _____ good _____ fair _____ poor _____

What serious illnesses, operations or injuries has the patient experienced?

_____

_____

GROWTH HISTORY (Omit if patient is an adult)

a. If patient is female: Is she an early, average or late maturer? ..... _____

Has she started her monthly period? ..... _____

If so, when? ..... _____

Are there older sisters in the family? ..... _____

b. If patient is male: Is he an early, average or late maturer: ..... _____

Are there older brothers in the family? ..... _____

c. What is the height of the patient's father? _____

mother? _____

ADULT FEMALE PATIENTS

Are you pregnant? _____

- over -

Are any of the following conditions present or in the past history of the patient:

	No	Yes
Allergies		
Heart ailment		
Asthma		
Diabetes		
Tonsillitis		
High or low blood pressure		
Cold sores or fever blisters		
Hepatitis		
Rheumatic fever		
High or low thyroid		
Dizziness, fainting		
Epilepsy		
Injuries to face, mouth, teeth		
Psychological disturbances		
Other serious illnesses		
Have tonsils and adenoids been removed?		
Have any teeth been injured or loosened by a fall or blow?		
Is the patient concerned about the appearance of the teeth?		
chewing function?		
health of the mouth?		
Does any member of the family or close relatives have a similar arrangement of teeth or appearance?		
Has any member of the family had orthodontic treatment?		
Is the patient's attitude toward wearing braces one of :		
eagerness		
indifference		
antagonism		
When are the teeth routinely brushed?		
morning		
after lunch		
after dinner		
before bed		
Does the patient have difficulty in chewing or swallowing food?		
Have any of the following problems been noted in the past:		
thumb or finger sucking		
lip biting		
chronic mouth breathing while awake		
chronic mouth breathing while asleep		
tongue thrusting during swallowing		
grinding or gnashing of teeth		
clicking or snapping of lower jaw joint		