Date

Patient's first name | Middle initial | Last name | Birthdate

Your physician's name | When did you last see your physician?

Tell us about the patient's medical history (For all questions, if yes, please give us more information):

- ○ Yes ○ No Are you taking any medications, including aspirin?
- ○ Yes ○ No Are you allergic to any medications?
- ○ Yes ○ No Do you have a history of major illnesses?
- ○ Yes ○ No Have you had any major operations?
- ○ Yes ○ No Have you ever been involved in a serious accident?
- ○ Yes ○ No Do you smoke? If yes, for how long?
- ○ Yes ○ No Do you have any allergies?

Check the medical conditions listed below that you have had or currently have:

- ○ Abnormal bleeding / hemophilia
- ○ Anemia
- ○ Arthritis
- ○ Asthma or hayfever
- ○ Bone disorders
- ○ Congenital heart defect
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy
- ○ Gastrointestinal disorders
- ○ Heart problems
- ○ Heart murmur
- ○ Hepatitis / liver problems
- ○ Herpes
- ○ High blood pressure
- ○ HIV / Aids
- ○ Kidney problems
- ○ Nervous disorders
- ○ Pneumonia
- ○ Prolonged bleeding
- ○ Radiation / chemotherapy
- ○ Rheumatic fever
- ○ Tuberculosis
- ○ Tumor or cancer

- ○ Yes ○ No Are there any other medical conditions we should be aware of? If yes, please tell us about them:
- ○ Yes ○ No *Female patients only*: Are you pregnant?
- ○ Yes ○ No *Female patients only*: Have you started menstruating?

Tell us about the patient's dental history (For all questions, if yes, please give us more information):

Your dentist's name | When did you last see your dentist?

Why are you coming to an orthodontist today?

- ○ Yes ○ No Have you ever seen an orthodontist? If yes, who and when?
- ○ Yes ○ No Has anyone in your family received orthodontic treatment? If yes, how did they feel about the result?

How do you feel about receiving orthodontic treatment?

Check the symptoms listed below that you have had or currently have:

- ○ Grinding
- ○ Clenching
- ○ TMJ problems
- ○ Joint noises (clicking)
- ○ Limitation of opening
- ○ Frequent headaches
- ○ Thumb/finger sucking
- ○ Traumas to teeth
- ○ Injury to jaws
- ○ Periodontal problems
- ○ Periodontal surgery
- ○ Mobility of teeth
- ○ Extractions of teeth
- ○ Nail biting
- ○ TMJ surgery
- ○ Missing teeth
- ○ Jaw surgery
- ○ Previous orthodontic treatment
- ○ Mouth breathing
- ○ Dryness of mouth

If your smile or facial appearance could be changed, what would you change?

- ○ Yes ○ No Have you ever received any unusual dental or surgical treatment to your mouth, teeth or jaws? If yes, please describe:

Signature (If patient is a minor, parent's or guardian's signature) | Date