smileLOGIC ORTHODONTICS

Health History Form

Oral Health History

Does the patient have any history of the following?

- Y N Pain in the jaw joints (TMJ)
- Y N Clicking of the jaw joints (TMJ)
- Y N Injury to the face or teeth
- Y N Difficulty chewing
- Y N Speech problems
- Y N Pen, lip, or nail biting
- Y N Thumb or finger sucking
- Y N Grinding teeth (day or night)
- Y N Mouth breathing
- Y N Snoring or sleep apnea
- Y N Extra teeth
- Y N Extraction of teeth
- Y N Missing teeth
- Y N Age-7 orthodontic checkup
- Y N Prior orthodontic treatment

What topics would you like to discuss at your first visit?

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If "Yes" to any of the above, please explain:

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Patient Medical History

Does the patient have any history of the following?

- Y N Allergy to acrylic, metal, or latex
- Y N Allergy to medication
- Y N Any hospitalization or surgery
- Y N Arthritis
- Y N Asthma
- Y N Blood or bleeding disorder
- Y N Diabetes
- Y N Heart disease
- Y N High blood pressure
- Y N HIV+ or AIDS
- Y N Liver disease, hepatitis, or jaundice
- Y N Medication containing bisphosphonates
- Y N Medication taken in past 7 days
- Y N Require antibiotics prior to dental treatment
- Y N Rheumatic fever
- Y N Seizures
- Y N Thyroid disease
- Y N Tobacco use
- Y N Tuberculosis

Female Patients

- Y N Has menstruation started?
- Y N Is the patient pregnant?

I have read and understood this form. The information I have given is correct to the best of my knowledge. I consent to a complete orthodontic evaluation. I authorize the taking of x-rays, photographs, and other necessary records before, during, and after treatment and to the use of the same by this practice for scientific papers and demonstrations.

______________________________ Patient Name

______________________________ Date of Birth

______________________________ Signature of Patient/Parent/Guardian

______________________________ Date