The following conditions are of interest to the orthodontist.
Has the patient ever had: (circle)

Aids	Diabetes	Heart Disease
Asthma	Epilepsy	Hearing Disorder
Anemia	Endocrine Problems	Head or Face Injury
Blood Disease	Emotional Problems	Rheumatic Fever
Bone Disorders	Hepatitis	Venereal Disease

COMMENTS: ______________________________

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____

Does the patient:

1. Have allergies to: Seasonal grasses __________ Food __________
   Drugs __________ Other __________
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually COMMENTS: __________
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose and throat specialist?
Yes No If YES: When __________ By Whom __________
Tonsils removed __________ Adenoids removed __________

Does the patient have pain or clicking in jaw joint? Yes No

Have any teeth been injured due to accidents or blows to the mouth? Yes No

Has the patient received or been requested to receive speech correction? Yes No

The following habits are of interest to the orthodontist. List information as it pertains to this patient:

Thumb sucking until age __________ Grinding of teeth Yes No
Finger sucking until age __________ Tongue thrusting Yes No
Lip-biting or sucking Yes No Other habits Yes No

Has the patient had any unusual dental experiences? Yes No
Specify: ______________________________

Has the patient had previous orthodontic consultation or treatment? Yes No
Date __________ Dr: ______________________________

Are there any other medical, dental or surgical problems not covered above? Yes No
Specify: ______________________________

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental checkups: Twice A Year Once A Year Only If Urgent Never

Date of last dental checkup __________ Were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problem? Yes No

Patient's interest in orthodontic treatment:
The Patient Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative

Orthodontic consultation prompted by: Patient Dentist Parent Spouse Other (specify) __________

What is your primary reason for seeking orthodontic treatment?

____

____

Additional comments you wish to make: ______________________________

____

____

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM: ______________________________

RELATIONSHIP TO PATIENT ______________________________ TODAY'S DATE __________