Are you in good health?	___ yes ___ no	Explain _____
Any major or unusual illnesses?	___ yes ___ no	Explain _____
Currently being tread by physician?	___ yes ___ no	Reason_____
Currently taking medication?	___ yes ___ no	Reason_____
Allergies	___ yes ___ no	List _____
Drug sensitivity	___ yes ___ no	List _____

Please check if you have or have had any of the following:

___ Anemia
___ Blood Disease
___ Prolonged Bleeding
___ Jaundice
___ Rheumatic Fever
___ Scarlet Fever
___ Hepatitis
___ Glaucoma
___ Heart Problems
___ Tuberculosis
___ Diabetes
___ Endocrine Problems
___ Bone disorders
___ Epilepsy
___ Herpes
___ Are you in a risk group for AIDS?
___ Frequent colds or flu
___Tonsillitis
___ Adenitis
___ Tonsils Removed: Age _____
___ Adenoids Removed: Age _____
___ Asthma
___Mouthbreathing:
While awake? ___
While asleep? ___

Dental History

Yes No

___ ___ Have you ever had any severe head or face injuries? Explain : _____

___ ___ Have you had a history of thumb sucking or finger sucking? ____ Stopped? _____When? _____

___ ___ Do you play any musical (wind) instrument? Explain: _____

___ ___ Have you consulted an orthodontist previously? Explain: _____

___ ___ Have you had any previous orthodontic treatment? Explain: _____

___ ___ Have any family members had orthodontic treatment? Who:_____

Please check if there is a history of:

___ Clenching teeth
___ Grinding teeth
___ Muscular soreness around head and neck
___ Headaches (more than normal)
___ Jaw joint soreness
___ Jaw joint popping
___ Ringing in the ears

Is there any information that may be helpful?

Thank you!

Signed:_____ Date:_____

Updates (date and initial) _____