PATIENT NAME _____ NO. _____ SEX: M ☐ F ☐

_____ AGE _____ / / DATE OF BIRTH _____ – – SOCIAL SECURITY NO.

NAME OF PHYSICIAN/GROUP _____ DR. TELEPHONE _____

**PLEASE DESCRIBE "YES" ANSWERS**

1. Date of last physical exam _____ ☐ Routine ☐ Illness
2. Have you been hospitalized in the last five years? ☐ Yes ☐ No
3. Are you undergoing any medical treatment? ☐ Yes ☐ No
4. Are you presently taking any medication? ☐ Yes ☐ No
5. Have you ever had a reaction to a medication? ☐ Yes ☐ No
6. Are you allergic to: *(Please check box)* ☐ Penicillin ☐ Aspirin
   ☐ Local Anesthetic ☐ Other Medications — Describe:
7. Do you bleed abnormally after cuts or extractions? ☐ Yes ☐ No
8. Have you ever been treated with X-Ray or radiation? ☐ Yes ☐ No
9. Have you taken steroids (Cortisone) in the past two years? ☐ Yes ☐ No
10. Do you smoke or use smokeless tobacco? How much? ☐ Yes ☐ No
11. Please check if you had any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ AIDS | ☐ Cancer | ☐ Glaucoma | ☐ Joint Replacements | ☐ Short of Breath |
| ☐ Alcohol Addiction | ☐ Chemotherapy | ☐ Hearing Problem | ☐ Kidney Disease | ☐ Sickle Cell Disease |
| ☐ Allergy | ☐ Chest Pain | ☐ Heart Disease | ☐ Learning Disability | ☐ (or) Trait |
| ☐ Anemia | ☐ Cold Sores | ☐ Heart Murmur | ☐ Liver Disease | ☐ Stroke |
| ☐ Ankles Swell | ☐ Diabetes | ☐ Heart Surgery | ☐ Mononucleosis | ☐ T.B. |
| ☐ Arthritis | ☐ Drug Addiction | ☐ Hepatitis A, B | ☐ Pacemaker | ☐ Tumor(s) |
| ☐ Art. Heart Valve | ☐ Epilepsy | ☐ Herpes I, II | ☐ Psychiatric Care | ☐ Thyroid Disease |
| ☐ Asthma | ☐ Emphysema | ☐ High Blood Pressure | ☐ Rheumatic Fever | ☐ Ulcer(s) |
| ☐ Blood Disease | ☐ Faint | ☐ Infectious Diseases | ☐ Scarlet Fever | ☐ Venereal Disease |
| ☐ Bruise Easily | ☐ Fatigue Easily | | | |

**JAW RELATED PROBLEMS**

| | | |
|---|---|---|
| ☐ Bite Feels Uncomfortable | ☐ Jaw "Gets Stuck" | ☐ Pain In/Around Ears |
| ☐ Difficulty Opening/Closing Mouth | ☐ Jaw "Goes Out" | ☐ Pain When Chewing, Yawning |
| ☐ Injury to Jaw, Neck, Head | ☐ Jaw-Joint Noises | ☐ Pain When Opening Wide |
| | ☐ Jaw Muscles Tender | ☐ Previous Treatment for Jaw Problems or (TMJ) |

12. (WOMEN) Are you: ☐ Pregnant ☐ or Take Birth Control Pills ☐ Yes ☐ No **COMMENTS:** _____
13. Are there any other physical, mental or emotional problems we should be aware of? ☐ Yes ☐ No
14. Who can we thank for this referral? _____

**CHILDHOOD INFORMATION**

☐ Still Uses Baby Bottle ☐ Takes Fluoride Supplement ☐ Previous Orthodontic Treatment ☐ Frequent Snacking ☐ Poor Dental Experience(s)

☐ Habits: ☐ Thumb Sucking ☐ Finger Sucking ☐ Pacifier ☐ Other _____

Is there anything else we should know about your child? _____

***PLEASE COMPLETE BACK SIDE***

## HEALTH HISTORY AND UPDATES