

MEDICAL HISTORY

Is patient in good health? Yes _____ No _____

Does patient have any history of major illness? Yes _____ No _____

Has the patient ever been under the care of a physician for illness? Yes _____ No _____

Please List _____

Check any of the following for which the patient has been treated:

Diabetes _____ Tuberculosis _____ Endocrine Problems _____

Pneumonia _____ Anemia _____ Prolonged Bleeding _____

Heart Trouble _____ Epilepsy _____ Fainting & Dizziness _____

Rheumatic Fever _____ Asthma _____ Nervous Disorders _____

Bone Disorders _____ Kidneys _____ Liver _____

High Blood Pr. _____ Hepatitis _____ Venereal Disease _____

Blood Transfusion _____ Emotional Pr. _____ HIV Positive _____

Frequent Colds _____ Sore Throats _____ Ear Infections _____

List any drugs or medications now being taken. Give Reasons:

List any allergies or drug sensitivity: _____

Are you pregnant? _____ If yes, what trimester? _____

DENTAL HISTORY

Does the patient need to be pre-medicated for dental treatment? Yes _____ No _____

Has there been any injury to the face, mouth or teeth? Yes _____ No _____

Has the patient ever sucked a thumb or fingers? Yes _____ No _____ If yes, until what age? _____

Does the patient have any speech problems? Yes _____ No _____

Is the patient a mouth breather? While awake? Yes _____ No _____ While asleep? Yes _____ No _____

List any musical instruments played: _____

Have you been informed of any missing or extra permanent teeth? Yes _____ No _____

Are there any medical, dental, or surgical problems not covered above? Yes _____ No _____

Has an orthodontist been consulted previously? Yes _____ No _____

Reason for consultation _____

EMERGENCY CONTACT INFORMATION

Name of the Person: _____

Relationship to You: _____

Complete Address: _____

Phone: _____

I have read and understand the above questions. I have answered each one accurately and to the best of my knowledge. If there are any changes to the history and medical/dental record, I will so inform the staff at Allura Orthodontics.

Signature and Date: _____

Print Name: _____