Patient Name: _____ DOB: ___/___/_____

Medical History

Please fill out this section to the best of your knowledge. It is important for us to be aware of any health issues that may affect the treatment you receive from our office. This information is kept strictly confidential.

Physician _____
Date of Last Visit _____/_____/_____

- □ Check if ALL immunizations are NOT current?
- □ Check if the Patient is Pregnant?
- □ Check if any diet pills, such as Phen-Fen, have ever been taken?
- □ Check if Fosamax or any other bisphosphonate have ever been taken?

If the patient is under 18: □ Check if puberty has begun? □ Check if menstruation has begun?

Please check any of the following which apply to you, and add any relevant comments:

□ Are any medications being taken? List All:

_____

_____

_____

□ Are there any allergies? List All:

_____

_____

□ Is there a history of any major illness? Please Explain:

_____

_____

Please check any of the following that you have had or currently have:

□ Abnormal Bleeding / Hemophilia	□ Epilepsy / Seizures	□ Nervous Disorders
□ ADD / ADHD	□ Frequent Headaches / Migraines	□ Pneumonia
□ Adenoids / Tonsils Removed	□ Gastrointestinal Disorders	□ Prolonged Bleeding
□ Alcohol / Drug Abuse	□ Handicaps / Disabilities:	□ Psychiatric Problems
□ Anemia	_____	□ Radiation / Chemotherapy
□ Arthritis	□ Heart Problems, Heart Attack	□ Rheumatic Fever
□ Asthma	□ Heart Surgery, Pacemaker	□ Scarlet Fever
□ Artificial Bones / Joints / Valves	□ Heart Murmur	□ Sickle Cell Disease / Traits
□ Autoimmune Condition	□ Hepatitis / Liver Problems	□ Shingles
□ Blood Transfusion	□ High Blood Pressure	□ Sinus Problems
□ Bone Disorders	□ HIV / Aids	□ Stroke
□ Cancer / Chemotherapy	□ Hormone Problems	□ Thyroid Problems
□ Congenital Heart Defect	□ Hospitalizations	□ Tobacco Product Usage
□ Convulsions	□ Low Blood Pressure	□ Tuberculosis
□ Diabetes	□ Kidney Problems	□ Tumor or Cancer
□ Difficulty Breathing	□ Major Operations	□ Ulcers
□ Dizziness	□ Metal Pins / Rods / Implants	
□ Emphysema	□ Mitral Valve Prolapse	

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

_____

Dental History

General Dentist _____

Date of Last Visit _____/_____/_____

What are the main objectives that you would like Orthodontics to accomplish?

_____

_____

Please list any concerns that you have regarding Orthodontic treatment:

_____

_____

Please check box to indicate Yes for the following questions -- Leave blank for No:

- ☐ Have you ever seen another Orthodontist?
  - If yes, Who? _____
  - When? _____
- ☐ Have you ever had Orthodontic treatment before?
  - If yes, type of treatment _____
  - When? _____
- ☐ Are antibiotics required for dental treatment?
- ☐ Are the teeth brushed at least twice daily?
- ☐ Are the teeth flossed daily?
- ☐ Are there extra permanent teeth?
- ☐ Are there any missing permanent teeth?
- ☐ Is there presently any dental pain?
- ☐ Is there a current lip sucking / lip biting issue?
- ☐ Is there a current speech problem?
- ☐ Has there ever been an unfavorable reaction to dentistry?
- ☐ Has there been any injuries to face, mouth or teeth?
- ☐ Is there any pain or tenderness in the jaw joint?
- ☐ Have you ever been told that you grind your teeth?
- ☐ Do the teeth or jaws ever feel sore upon waking in the morning?
- ☐ Are you aware of your jaws clicking or popping?
- ☐ Are you aware of clenching your teeth during the day?
- ☐ Do you have 'tension' headaches?

TMJ/TMD Comments:

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in medical / dental status. I authorize Dr. Curtis E. Trammell & staff to perform any necessary dental and or orthodontic services that are needed during diagnosis and treatment, bill insurance and allocate payments, with my informed consent.

Signature _____ _____/_____/_____