

PATIENT NAME _____ NO. _____ SEX: M F

AGE _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

NAME OF PHYSICIAN/GROUP _____ DR. TELEPHONE _____

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
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:

PLEASE DESCRIBE "YES" ANSWERS

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Describe: _____

Yes No _____

Yes No _____

Yes No _____

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

JAW RELATED PROBLEMS

- | | | |
|---|---|---|
| <input type="checkbox"/> Bite Feels Uncomfortable | <input type="checkbox"/> Jaw "Gets Stuck" | <input type="checkbox"/> Pain In/Around Ears |
| <input type="checkbox"/> Difficulty Opening/Closing Mouth | <input type="checkbox"/> Jaw "Goes Out" | <input type="checkbox"/> Pain When Chewing, Yawning |
| <input type="checkbox"/> Injury to Jaw, Neck, Head | <input type="checkbox"/> Jaw-Joint Noises | <input type="checkbox"/> Pain When Opening Wide |
| | <input type="checkbox"/> Jaw Muscles Tender | <input type="checkbox"/> 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

- | | | |
|--|---|--|
| <input type="checkbox"/> Still Uses Baby Bottle | <input type="checkbox"/> Previous Orthodontic Treatment | <input type="checkbox"/> Poor Dental Experience(s) |
| <input type="checkbox"/> Takes Fluoride Supplement | <input type="checkbox"/> Frequent Snacking | |
- 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