

Dental History

Date History Reviewed _____

Why does patient desire an examination (bite, crookedness, "TMJ", etc.)? _____

Patient's Dentist _____ When was your last dental visit? _____

Has patient had previous orthodontics? _____ If so, state the orthodontist, where, when and treatment received: _____

**Concerns about X-rays? _____

	NO	YES		NO	YES
Teeth Throb or Ache, Sensitivity to Hot or Cold	<input type="checkbox"/>	<input type="checkbox"/>	Bone Loss, Periodontal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Irritations to Cheek, Lip, Tongue, Palate	<input type="checkbox"/>	<input type="checkbox"/>	Any Oral Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Canker Sores, Cold Sores, Cyst, Abscesses	<input type="checkbox"/>	<input type="checkbox"/>	Facial Trauma/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Lip, Cheek or Tongue-Biting	<input type="checkbox"/>	<input type="checkbox"/>	Chipped or Injured Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Food Impaction Between Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Missing or Extracted Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums, Gingivitis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Breathing, Chewing	<input type="checkbox"/>	<input type="checkbox"/>
Gum Recession	<input type="checkbox"/>	<input type="checkbox"/>	Mouth-breather	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			Thumb or Finger-sucking Habit	<input type="checkbox"/>	<input type="checkbox"/>

Medical History

Patient's Physician and/or Health Care Provider _____

Health Status (good, fair, poor, continuing problems, etc.)? _____

Under a Physician's care? _____ If yes, for what? _____

List of Medications — Prescription & "Over the Counter" _____

List any Allergies: _____

List any Types of Surgery: _____ Blood Transfusions? _____

	NO	YES		NO	YES
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Problems/Defects	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections, Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus/Airway Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur or Valvular Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever or Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Treated with X-Ray Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic Hip or Joint	<input type="checkbox"/>	<input type="checkbox"/>	Herpes, Epstein Barr Virus, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease, Hemophilia, Anemia	<input type="checkbox"/>	<input type="checkbox"/>	AIDS, AIDS Related Complex	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Smoking or Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Women — Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other diseases/disorders/etc. _____		

TMJ - Facial Pain History

	NO	YES		NO	YES
Clench/Grind your Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Clicking, Popping, etc., Sounds from Jaw Joint	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Open/Close Irregularly	<input type="checkbox"/>	<input type="checkbox"/>	Ever Received a Severe Blow to the Jaw or Head	<input type="checkbox"/>	<input type="checkbox"/>
TMJ Related Head or Neckaches	<input type="checkbox"/>	<input type="checkbox"/>	Are you Under a Lot of Stress?	<input type="checkbox"/>	<input type="checkbox"/>
Muscles Tire with Normal Chewing	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Tenderness in your Cheek/Facial Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Time of day most TMJ problems occur: _____			Episodes of Limited Jaw Opening/Closing/Locking	<input type="checkbox"/>	<input type="checkbox"/>

What brings on or starts your TMJ problem: _____

Ever been treated for Jaw Joint Problems, facial muscle spasms or worn a night guard/splint: _____

Describe your problem in words: _____

I have completed the patient information and medical/dental history section to the best of my knowledge and have not withheld any information that may affect either myself or the dental staff during treatment. I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's/Guardian's signature if minor) _____ Date _____