Ortho Smiles

HEALTH HISTORY

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):*	
Name of dentist:	
Date of last dental visit:	**Date of last dental X-ray:**

DENTAL HISTORY			
Check if you have had any of the following:			
☐ How often do you floss?		☐ How often to do you brush?	
☐ Bad breath	☐ Food collection between teeth	☐ Sucked your thumb/fingers	☐ Do you have headaches
☐ Do you grind your teeth	☐ Do you have speech problems	☐ Have your tonsils been removed	☐ Do you snore
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Have your adenoids been removed	☐ Bleeding gums
☐ Have you had previous orthodontic consultation/treatment? If so, when and by whom?			
☐ Are you willing to wear braces?			
☐ What are the patient's favorite hobbies, sports, or play a musical instrument?			

MEDICAL HISTORY		
Physician's name:		**Date of last visit:**
☐ Rheumatic Fever	☐ Liver or Kidney Disease	☐ Jaundice
☐ Heart Problems	☐ Blackouts/Fainting Attacks/Giddiness	☐ Hepatitis
☐ Heart Murmur	☐ Have you ever been on tablets for Cancer/Osteoporosis	☐ Epilepsy
☐ High Blood Pressure	☐ Bleeding Disorder	☐ Asthma
☐ Heart Surgery/Pacemaker	☐ Diabetes	☐ Chest Problems
☐ ADHD	☐ Have had or carrier of a blood borne virus Ex: HIV	☐ Hay fever
☐ Other:	☐ Apprehensive/Sensitive: If so, explain:	

MEDICATIONS	**ALLERGIES**
List all medications you are taking below:	☐ Aspirin
	☐ Codeine
	☐ Local Anesthetic
	☐ Penicillin
	☐ Latex
☐ Do you require pre-medication with antibiotics prior to dental procedures?	☐ Other:
☐ **Please list any family members seen in this office**:	

Signature: _____ **Date:** _____

With whom may we discuss treatment/financial matter with:_____