MEDICAL HISTORY

DATE_______________
PATIENT NAME________________________________
PHYSICIAN____________________________________

Please circle YES or NO (If YES, please fill in the details)

YES NO Is the patient taking any medication?____
YES NO History of major illness?____
YES NO Ever involved in a serious accident?____
YES NO Frequent headaches? How Often?____
YES NO Does the patient eat a high sugar diet?
YES NO History of osteoporosis?
YES NO History of eating disorder? (anorexia, bulimia)____
YES NO Does the patient have a heart condition? If so, do you pre-medicate prior to dental procedures?___________

Female Patients Only:

YES NO Has menstruation started? If Yes, Date____
YES NO Is the patient pregnant?____

For Adult Patients:

YES NO Have you ever taken oral bisphosphonates such as Fosomax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate) for bone disorders?

Circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver Problems	Pneumonia	
Anemia	Dizziness	Herpes	Prolonged Bleeding	
Arthritis	Epilepsy	High Blood Pressure	Heart Murmur	
Asthma or Hayfever	Gastrointestinal Disorders	HIV/AIDS	Rheumatic Fever	
Bone Disorders	Nervous Disorders	Kidney Problems	Tuberculosis	Tumor or Cancer

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

ALLERGIES or REACTIONS to any of the following?

YES NO Local anesthetics(novocaine, lidocaine, xylocaine)
YES NO Latex (gloves, balloons)
YES NO Aspirin
YES NO Ibuprofen (Motrin, Advil)
YES NO Penicillin
YES NO Other antibiotics
YES NO Metals (jewelry, clothing snaps)
YES NO Acrylics

AIRWAY/BREATHING DISORDERS

YES NO Have you had your tonsils and/or adenoids removed?
YES NO Ear problems? (aches, ringing, dizziness, fullness)
YES NO Mouth breathing habit or snoring at night?
YES NO Sleep Apnea?
YES NO Daytime Sleepiness?
YES NO Poor Sleep Quality?
YES NO Nasal Congestion?
YES NO Do you notice patient posturing head forward?
YES NO Is/Was the patient tongue-tied?

DENTAL HISTORY

GENERAL DENTIST____DATE OF LAST VISIT______________________
What concerns you most about your teeth?____
Please circle YES or NO (If YES, please fill in the details)

YES NO Has the patient ever been seen by an orthodontist before?
YES NO Injuries to the patient$ teeth?____
YES NO Has the patient had any teeth extracted?____
YES NO Habits such as nail biting, lip or cheek biting, finger or thumb sucking(how long?)___________________________
YES NO Do you have speech problems, or are you in speech therapy?____
YES NO Has the patient ever been diagnosed with gum disease or pyorrhea? ______________________________________
YES NO Has the patient ever been treated for TMJ or TMD problems? ____
YES NO Pain, clicking, and/or popping noises in the jaw? ____
YES NO Are you aware of either clenching or grinding of teeth? ____
YES NO Soreness in jaw muscles or face muscles? ____

Height of Birth Parents: Mom__________________ Dad__________________________

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in the general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth can change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understood this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Lenhart to perform a complete orthodontic evaluation.

Signature:____Date:____________________________________