Physician: _____ Dentist_____

Does the patient:

Yes	No	
○	○	have any health problems (current or past)_____
○	○	take any medications (current or past) _____Phen-fen_____
○	○	currently see a physician for a medical condition _____
○	○	have allergies (itching, rash, swelling, sensitivity) to anything _____
○	○	have a history of any illnesses or hospitalizations _____
○	○	have a history of any surgery or major medical problems _____
○	○	use drugs, alcohol or tobacco _____
○	○	have trouble breathing through the nose (mouth breather) _____
○	○	have a tendency for ear infections or noises in the jaw joint _____
○	○	have any pain or clicking in the jaw joint or head/neck regions _____
○	○	have any history of trauma to the jaw or face_____
○	○	experience frequent headaches, or head/neck pain _____
○	○	play any wind/reed instruments or the violin _____
○	○	have negative reactions or experiences to any type of dental work _____
○	○	need to take medications before dental work because of a heart or valve condition_____

Has the patient ever had any of the following:

Yes	No		Yes	No	
○	○	Heart trouble, congenital heart lesions	○	○	Diabetes or a family history of same
○	○	Heart murmur, heart pacer	○	○	Excessive chronic thirst
○	○	High or low blood pressure	○	○	Thyroid disorders or family history
○	○	Rheumatic fever, heart valve problems	○	○	Endocrine disturbances
○	○	Arteriosclerosis or stroke	○	○	Anemia, blood diseases
○	○	Chest pains on mild exertion	○	○	Bleeding disorders, prolonged bleeding
○	○	Shortness of breath on mild exertion	○	○	Arthritis, sore or swollen joints
○	○	Kidney disease or problems	○	○	Tuberculosis, chronic or frequent coughs
○	○	Excessively swollen ankles or tissues	○	○	Mononucleosis or other viral diseases
○	○	Anorexia, Bulimia	○	○	HIV virus or AIDS
○	○	Venereal disease	○	○	Ulcers, internal bleeding
○	○	Scarlet Fever	○	○	Emphysema, breathing problems
○	○	Liver disease	○	○	Asthma, respiratory problems
○	○	Hepatitis, jaundice, liver problems	○	○	Radiation treatment, chemotherapy
○	○	Hearing problems, ringing in the ears	○	○	Malignancies, tumors or growths
○	○	Cold sores, herpetic lesions, cankers	○	○	Epilepsy or seizures
○	○	Skin rash, lesions, hives, fever blisters	○	○	Hyperactivity, nervousness
○	○	Prostate disorders	○	○	Fainting, dizziness, and unconsciousness
○	○	Glaucoma, cataracts	○	○	Chronic exhaustion or fatigue
○	○	Sudden weight change	○	○	Chronic nervousness, high stress
○	○	Trauma to face, chin or jaw	○	○	Chronic unhappiness or depression
○	○	Frequent chronic headaches	○	○	Emotional problems or tension
○	○	Blood transfusion, if so, when _____	○	○	Psychiatric treatment_____

For female patients, is the patient now:

Yes	No		Yes	No	
○	○	Pregnant	○	○	Presently in menopause
○	○	Taking birth control	○	○	Past menopause

Please explain fully any "Yes" answers above, or any family history of any of the above conditions.

_____

Please explain your orthodontic concerns and what you would like orthodontics to accomplish for you.

_____

I certify that the information above is true and accurate and that if there are any changes in this medical history, that I will notify this office. I agree to allow Dr. Brown to discuss or share this information with whomever he deems necessary.

Patient/Legal guardian signature _____ Date _____