

# 4 MEDICAL INFORMATION

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
Any Heart Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immune Deficiency Syndrome:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur:	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Hay Fever:	<input type="checkbox"/>	<input type="checkbox"/>
Any Respiratory Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Is Patient Under Medical Care:	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis:	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis:	<input type="checkbox"/>	<input type="checkbox"/>
Any Blood Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism or Arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis:	<input type="checkbox"/>	<input type="checkbox"/>	Any Broken Bones:	<input type="checkbox"/>	<input type="checkbox"/>
Any Liver Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Is the Patient taking any Medications:	<input type="checkbox"/>	<input type="checkbox"/>	Polio:	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding:	<input type="checkbox"/>	<input type="checkbox"/>
Any Thyroid Disease:	<input type="checkbox"/>	<input type="checkbox"/>	A History of Fainting or Dizziness:	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice:	<input type="checkbox"/>	<input type="checkbox"/>
Any Kidney Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Does the Patient have a Drug Addiction:	<input type="checkbox"/>	<input type="checkbox"/>	Anemia:	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy:	<input type="checkbox"/>	<input type="checkbox"/>
H.I.V. Positive:	<input type="checkbox"/>	<input type="checkbox"/>	Is the Patient Pregnant at this Time:	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia:	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Therapy:	<input type="checkbox"/>	<input type="checkbox"/>
Any Venereal Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Measles/Mumps/Chicken Pox:	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema:	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions:	<input type="checkbox"/>	<input type="checkbox"/>
Any Intestinal Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Does the Patient Smoke:	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy:	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy:	<input type="checkbox"/>	<input type="checkbox"/>
Any Bone Disease:	<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient ever had Fever Blisters:	<input type="checkbox"/>	<input type="checkbox"/>	Is the Patient Allergic to Anything:					
Any Nervous /Emotional Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Is Height & Weight Normal for Age:	<input type="checkbox"/>	<input type="checkbox"/>	What: _____					
Any High or Low Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Is the Patient in Good Health:	<input type="checkbox"/>	<input type="checkbox"/>	List any Medications: _____					
Any Endocrine Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient had a Physical this Year:	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of any other disease, condition, or					
Any Problems with Wounds Healing:	<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient Reached Puberty:	<input type="checkbox"/>	<input type="checkbox"/>	problem not listed above that we should know about:					
Any Tumors or Cancer:	<input type="checkbox"/>	<input type="checkbox"/>	If Female: Age began menstruating:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, What: _____					

# 5 DENTAL HISTORY

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>		
Has the Patient Seen a General Dentist in the Last Year:	<input type="checkbox"/>	<input type="checkbox"/>	Does the Patient Have or Ever Had Any of the Following Habits:				
Any Pain, Clicking or Discomfort In or Near the Ears:	<input type="checkbox"/>	<input type="checkbox"/>	Cheek, Tongue or Lip Chewing:	<input type="checkbox"/>	<input type="checkbox"/>		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:	<input type="checkbox"/>	<input type="checkbox"/>	Thumb Sucking:	<input type="checkbox"/>	Clenching Teeth:	<input type="checkbox"/>	<input type="checkbox"/>
Have You Been Informed of Missing or Extra Permanent Teeth:	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing:	<input type="checkbox"/>	Tongue Thrusting:	<input type="checkbox"/>	<input type="checkbox"/>
Are You Aware of Any "Gum" Problems:	<input type="checkbox"/>	<input type="checkbox"/>	Finger Nail Biting:	<input type="checkbox"/>	Grind Teeth:	<input type="checkbox"/>	<input type="checkbox"/>
Have the Patient's Tonsils or Adenoids Been Removed:	<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient Been Examined by an Orthodontist Before:	<input type="checkbox"/>	Speech Problems:	<input type="checkbox"/>	<input type="checkbox"/>
Do You Feel the Patient can Benefit From Orthodontic Treatment:	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, When: _____				
Is the Patient Happy with Their "SMILE":	<input type="checkbox"/>	<input type="checkbox"/>	Have Other Members of the Family had Orthodontic Treatment:	<input type="checkbox"/>			
Does the Patient Want to Improve Their "SMILE" and "BITE":	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, Were You Happy With the Results:	<input type="checkbox"/>			
Would the Patient Mind Wearing "BRACES":	<input type="checkbox"/>	<input type="checkbox"/>	If No, Why: _____				

In Your Own Words What is the Orthodontic Problem: \_\_\_\_\_

What Would you Like Orthodontic Treatment to Accomplish: \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained:

\_\_\_\_\_

\_\_\_\_\_ **Patient Signature**
\_\_\_\_\_ **Date**
\_\_\_\_\_ **Parent Signature**

# 6 TMJ HISTORY (IF APPLICABLE)

<p>Do you have clicking, popping, or grating noises in your</p> <p>RIGHT JAW JOINT? .....YES ...NO</p> <p>LEFT JAW JOINT? .....YES ...NO</p> <p>When did you first notice the noise? _____</p> <p>Has the noise recently become more pronounced? ....YES ...NO</p> <p>Do you have pain in or around RIGHT JAW JOINT? ..YES ...NO</p> <p style="padding-left: 100px;">LEFT JAW JOINT? ...YES ...NO</p> <p>When did you first notice the pain? _____</p> <p>Has the pain recently become more pronounced? .....YES ...NO</p> <p>When is the pain worse? Mornings _____ Evenings _____</p> <p>At Meals _____ No Specific Time _____</p> <p>What kind of pain? Dull _____ Continuous _____ Throbbing _____</p> <p>Stabbing _____ Intermittent _____ Other _____</p> <p>Does the pain feel like it is in your ear? .....YES ...NO</p> <p>Do you think your hearing has been affected? .....YES ...NO</p> <p>Are our daily activities affected? .....YES ...NO</p> <p>Are you taking or have you taken medication for symptoms related to your jaw? .....YES ...NO</p> <p>Did anything occur that might be related to the onset of this condition? .....YES ...NO</p> <p>Explain: _____</p>	<p>Do you have difficulty chewing? .....YES ...NO</p> <p>Has your mouth ever locked open so you were unable to close it? .....YES ...NO</p> <p>Explain: _____</p> <p>Have you ever had problems opening your mouth wide? ..YES ...NO</p> <p>Please indicate the time sequence in which you became aware of the following symptoms (1st, 2nd, etc.) and list only those which apply to you: Pain ___ Noise ___ Limited Opening ___ Locking ___ Other ___</p> <p>What aspect of your symptoms concern you the most? _____</p> <p>_____</p> <p>Are you aware of clenching your teeth? .....YES ...NO</p> <p>Do you grind your teeth? .....YES ...NO</p> <p>Has there been a recent change in your lifestyle such as marital status, childbirth, employment, death in your immediate family, or any other stressful events? .....YES ...NO</p> <p>Does nervous tension seem to affect you? .....YES ...NO</p> <p>Have you had problems with other joints? .....YES ...NO</p> <p>Have you had orthodontic treatment? .....YES ...NO</p> <p>Have you had recent dental treatment? .....YES ...NO</p> <p>Have you had x-rays taken for these symptoms? .....YES ...NO</p>
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