



WHITE ORTHODONTICS

Medical History

Name _____ Physician _____

How is your general health? Excellent ___ Good ___ Fair ___ Poor ___

Please check any of the medical conditions below that you have had or currently have:

- | | | | |
|--------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Abnormal bleeding//Hemophilia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hormone Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Airway Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tumor or Cancer |
| <input type="checkbox"/> Allergies Medicines/Latex | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Prolonged Bleeding | |
| <input type="checkbox"/> Asthma or Hay fever | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Radiation/Chemotherapy | |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | |

Are you pregnant? ___ Yes ___ No

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

Are you currently under medical treatment or taking any medication? ___ Yes ___ No

Please describe _____

Have you had any trauma to your head, neck face or mouth regions? ___ Yes ___ No

Please describe _____

Dental History

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

Do you smoke or chew tobacco? _____

Have you ever noticed any noises (popping, clicking, grinding) in your jaw joint area? ___ Yes ___ No

Have you ever had any pain in your jaw joint area? ___ Yes ___ No

Have you ever had an episode where you could not open or close your jaw? ___ Yes ___ No

Do you have any dental treatment or fillings planned for the near future? ___ Yes ___ No

Have you ever been treated for periodontal (gum) pockets or disease? ___ Yes ___ No

Any type of thumb or tongue habit? ___ Yes ___ No

Is the patient a mouth breather? ___ Yes ___ No

Has the patient ever seen an orthodontist? ___ Yes ___ No If yes who and when? _____

Are you aware that some appointments will be during school/work hours? ___ Yes ___ No

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. White to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

WHITE ORTHODONTICS

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