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CHRISTIAN MANLEY ORTHODONTICS EST. 1991

DENTAL HEALTH HISTORY

Patient Name: _____

Check if you have had problems with any of the following:

___Any injuries to face, mouth, teeth?
___ More than average amount of decay?
___ Any extra permanent teeth?
___Any difficulty swallowing/chewing?
Is patient adopted? Y ( ) N ( ) What age? ____
___Thumb, finger, lip sucking?
___Any missing permanent teeth?
___ Any teeth removed by extraction?
___Any pain or clicking when opening?
___ Do you snore? ___ Do you breathe through your mouth

Do you visit the dentist regularly? ____Date of last visit? _____Has an orthodontist been consulted previously? ___ Reason_____

Do you or have you taken any of the following medications: ___ Actonel ___ Boniva ___ Fosamax ___ Skelid ___ Didronel

What would you like orthodontic treatment to accomplish? _____

Patient's attitude toward orthodontic treatment? ___ Very motivated ___ Will cooperate if needed ___ Not motivated

MEDICAL HISTORY

Physician's Name_____ Phone_____ Date of last visit_____

Have you had any serious illnesses or operations? ___ Yes ___ No If yes, describe_____

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.) ___ Yes ___ No

Have you ever had a blood transfusion? ___ Yes ___ No If yes, give approximate Dates_____

List any serious illnesses _____ Is patient presently under physicians care for illness ___ Yes ___No
If yes, Reason_____

(Women) Are you pregnant? ___ Yes ___ No

Adolescent Females: Has menstruation begun __Yes __No If yes, Date: Month _____ Year _____ Approximately how much has patient grown in last year? _____

Check if you have or have had any of the following:

___ Anemia
___ Arthritis, Rheumatism
___ Artificial Heart Valves
___ Artificial Joints
___ Asthma
___ Back Problems
___ Cancer
___ Chemical Dependency
___ Chemotherapy
___ Cough, Persistent
___ Diabetes
___ Epilepsy
___ Fainting
___ Glaucoma
___ Headaches
___ Heart Murmur
___ Heart Problems
___ Hepatitis
___ Hemophilia
___ HIV/AIDS
___ High Blood Pressure
___ Jaw Pain
___ Kidney Disease
___ Liver Disease
___ Lupus
___ Mitral Valve Prolapse
___ Pacemaker
___ Radiation Treatment
___ Respiratory Disease
___ Rheumatic Fever
___ Skin Rash
___Scarlet fever
___ Shortness of Breath
___ Stroke
___ Swelling of Feet or Ankles
___ Thyroid Problems
___ Tobacco Habit
___ Tonsillitis
___ Tuberculosis

MEDICATIONS

List medications you are currently taking:

_____

_____

_____

ALLERGIES

Y N
( ) ( ) Latex
( ) ( ) Local Anesthetic
( ) ( ) Other – If yes please list _____
_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my orthodontist or any member of his/her team responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record of medical/dental status I will also inform the practice.

Signature_____ Date_____