4. MEDICAL INFORMATION

	YES	NO
Any heart disease	___	___
Any respiratory disease	___	___
Any blood disease	___	___
Any liver disease	___	___
Any thyroid disease	___	___
Any kidney disease	___	___
HIV positive	___	___
Any Venereal disease	___	___
Any intestinal disease	___	___
Any bone disease	___	___
Nervous/emotional problems	___	___
High or low blood pressure	___	___
Problems with wounds healing	___	___
Any tumors or cancer	___	___
Rheumatic/yellow/scarletfever	___	___
Acquired immune deficiency	___	___
s patient under medical care	___	___
Rheuamatism or Arthrities	___	___

	YES	NO
Is patient taking any medication	___	___
History of fainting or dizziness	___	___
Any drug addiction	___	___
Measle./mumps/chicken pox	___	___
Does patient smoke	___	___
Is patient in good health	___	___
Is Height/weight normal for age	___	___
Fever blisters	___	___
Has patient had a physical this year	___	___
Has patient reached puberty	___	___
Heart murmor	___	___
Mononucleosis	___	___
Hepatitis	___	___
Polio	___	___
Polio	___	___
Diabetes	___	___
Anemia	___	___
Hemophilia	___	___

	YES	NO
Emphysema	___	___
Epilepsy	___	___
Asthma, Hay fever	___	___
Tuberculosis	___	___
Broken Bones	___	___
Prolonged bleeding	___	___
Yellow jaundice	___	___
Radiation therapy	___	___
Chemical therapy	___	___
Blood transfusions	___	___
Is the patient allergic to anything?	___	___

What?_____

List any medications_____

_____

Are you aware of any other disease, conditions or problems not listed above that we should know about?_____

5. DENTAL HISTORY

	YES	NO
Has patient seen a general dentist in the last year?	___	___
Any pain, clicking or discomfort in or hear the ears?	___	___
Has the mouth, face or teeth been injured by a fall or accident?	___	___
Have you been informed of missing or extra permanent teeth?	___	___
Are you aware of any "gum" problems?	___	___
Has a physician or dentist advised antibiotics before dental exam?	___	___
Have the patient's tonsils or adenoids been removed?	___	___
Do you feel the patient can benefit from orthodontic treatments?	___	___
Is the patient happy with their smile?	___	___
Does the patient want to improve their smile or bite?	___	___
Would the patient mind wearing braces?	___	___

Does the patient have or ever had any of the following habits?

	YES	NO		YES	NO
Cheek, tongue or lip chewing	___	___	Clenching teeth	___	___
Thumb sucking	___	___	Tongue Thrusting	___	___
Mouth breathing	___	___	Grind teeth	___	___
Finger nail biting	___	___	Speech problems	___	___

	YES	NO
Has patient been examined by an orthodontist before	___	___
If yes, when _____		
Have other members of the family had orthodontic treatment	___	___
If yes, were you happy with the results	___	___
If no, why _____		

In your own words what is the orthodontic problems? _____

_____

What would you like orthodontic treatment to accomplish? _____

_____

_____ _____ _____

Patient Signature Date Parent Signature

ON THIS DATE, THE ABOVE GIVES PERMISSION FOR A CREDIT REPORT