CROCK ORTHODONTICS

MEDICAL HISTORY

Today's date:

Name:	Date of birth:
Physician:	Dentist:

GENERAL HEALTH	1. Are you in good health?	☐ yes	☐ no
	2. Have you had any change in your general health in the last year?	☐ yes	☐ no
	3. When was your last physical exam?		
	4. Are you taking any drugs or medications?	☐ yes	☐ no
	• List medications:		

ALLERGIES	1. Are you allergic to **latex**?	☐ yes	☐ no
	2. Do you have any **environmental allergies** or "hay fever"?	☐ yes	☐ no
	3. Have you ever had an allergic or adverse reaction to any of the below items?		
	• Local anesthetic such as Novocain?	☐ yes	☐ no
	• Penicillin, Amoxicillin, Sulfa, or other antibiotics? *(circle which)*	☐ yes	☐ no
	• Other drugs or medications? Which?	☐ yes	☐ no
	• Peanuts or other nuts?	☐ yes	☐ no
	• Bananas, avocados, chestnuts, hazelnuts, kiwis, tomatoes, or potatoes? *(circle which)*	☐ yes	☐ no

HEALTH HISTORY	1. Have you ever been hospitalized or had a serious illness? If yes, what?	☐ yes	☐ no
	2. Have your tonsils and/or adenoids *(circle which*) been removed? When?	☐ yes	☐ no
	3. Do you routinely take antibiotics prior to dental appointments?	☐ yes	☐ no
	4. Do you currently take (or have taken) bisphosphonates (Fosamax, Actone, Boniva)?	☐ yes	☐ no
	5. Do you have or ever had any of the following conditions?		
	• Rheumatic fever or rheumatic heart disease?	☐ yes	☐ no
	• Congenital heart defects or problems (e.g. heart murmur)?	☐ yes	☐ no
	• Heart disease, including heart attack, coronary occlusion or insufficiencies?	☐ yes	☐ no
	• High/low blood pressure, arteriosclerosis, stroke, pacemaker? *(circle which)*	☐ yes	☐ no
	• Chronic sinus trouble or sore throat?	☐ yes	☐ no
	• Mouth breathing? Snoring? Sleep apnea? *(circle which)*	☐ yes	☐ no
	• Asthma? Emphysema? *(circle which)* Do you use an inhaler?	☐ yes	☐ no
	• Shortness of breath?	☐ yes	☐ no
	• Fainting spells or seizures? *(circle which)*	☐ yes	☐ no
	• Diabetes or high blood sugar?	☐ yes	☐ no
	• Liver disease or jaundice?	☐ yes	☐ no
	• Tuberculosis? Heavy or persistent cough (especially one that brings up blood)?	☐ yes	☐ no
	• Heavy perspiration while sleeping?	☐ yes	☐ no
	• Any infectious diseases? *(circle which)* HIV, AIDS, hepatitis, other?	☐ yes	☐ no

BLOOD	1. Do you have any blood disorders? (e.g. anemia) If yes, which?	☐ yes	☐ no
	2. Have you ever had abnormal or excessive bleeding when cut?	☐ yes	☐ no
	3. Have you had any blood transfusions?	☐ yes	☐ no

OTHER	1. Have you had surgery or radiation treatment for a tumor or other condition?	☐ yes	☐ no
	2. Do you tobacco in any form? If yes, how much of what?	☐ yes	☐ no
	3. Do you have any disease or condition or health problem not listed above? Explain below, please.	☐ yes	☐ no

FEMALES ONLY	1. Are you pregnant or trying to become pregnant?	☐ yes	☐ no
	If yes, when is your projected due date?		

May we consult your physician, dentist, or other health care provider if we have questions about your medical history?	☐ yes	☐ no

DENTAL HISTORY

1. Do you have difficulty opening your mouth?	☐ yes	☐ no
2. Do you hear noises from the jaw joints when opening, closing, or chewing?	☐ yes	☐ no
3. Have your jaws ever locked closed or open?	☐ yes	☐ no
4. Do you have pain in or around your ears or cheeks?	☐ yes	☐ no
5. Do you have pain when chewing yawning, or opening wide?	☐ yes	☐ no
6. Does your bite feel uncomfortable or unusual?	☐ yes	☐ no
7. Have you ever had any injury to your jaws, head, or neck?	☐ yes	☐ no
8. Have you ever received treatment for temporomandibular disorder (TMJ)?	☐ yes	☐ no
9. Have you ever had any trouble associated with previous dental treatment?	☐ yes	☐ no
10. Have you ever received treatment for periodontal (gum) disease?	☐ yes	☐ no
11. Have you had any teeth removed by your dentist?	☐ yes	☐ no
12. Do you play a musical instrument? If yes, what?	☐ yes	☐ no
13. Do you have any of the following habits? (circle which)		
Finger sucking Thumb sucking Lip biting Ice chewing Nail biting		
14. When was your last dental exam?		

To the best of my knowledge, all of the answers above are true and correct. If there are any changes to my health or medications, I recognize that it is my responsibility to inform Dr. Crock.

Patient/Parent/Guardian signature _____ Date _____

Orthodontist's signature _____ Date _____