MEDICAL/HEALTH HISTORY

Patient name ______________________________ **UPDATED INFORMATION ON:** ____________
Date and Initial after reviewing for changes

Physician______________________________ Date of last visit ______________________________
Address______________________________ Phone ______________________________

Please circle Yes or No (if yes, please fill in details)

Yes No Are you presently, or have you ever been a smoker? ______________________________
Yes No Are you taking any medication? ______________________________
Yes No Are you allergic to latex or nickel? ______________________________
Yes No Do you have a history of a major illness? ______________________________
Yes No Have you had any major operations? ______________________________
Yes No Have you ever been involved in a serious accident? ______________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Congenital Heart Defect	Heart Murmur	Pneumonia
Adenoids Removed	Diabetes	Heart Problems	Prolonged Bleeding
Anemia	Dizziness	Hepatitis/Liver problems	Radiation/Chemotherapy
Arthritis	Epilepsy	Herpes	Rheumatic Fever
Asthma, Hay Fever, Allergies	Fainting	High Blood Pressure	Tonsils Removed
Bone Disorders	Growth Disorders	Nervous Disorders	Tuberculosis

Would you require PRE-MEDICATION prior to dental procedures?______________________________
Are there any medical conditions we have not discussed that you feel we should be aware of? ______________________________
____

DENTAL HISTORY

Dentist ______________________________ Date of last visit ______________________________
Address ______________________________ Phone (   ) ______________________________
WHAT CONCERNS YOU MOST ABOUT YOUR TEETH? ______________________________
____

Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________________________
Yes No Have you ever lost or chipped any teeth? ______________________________
Yes No Have there been any injuries to face, mouth or teeth? ______________________________
Yes No Have you any missing permanent teeth? ______________________________
Yes No Have you had teeth removed by extraction? ______________________________
Yes No Have you any difficulty swallowing or chewing? ______________________________
Yes No Do your gums bleed when you brush? ______________________________
Yes No Do you have any type of thumb or tongue habit? ______________________________
Yes No Are you a mouth breather? ______________________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________________
Yes No Has anyone in your family received orthodontic? ______________________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________________
Yes No Are you aware of your jaw clicking or popping? ______________________________
Yes No Are you aware of clenching your teeth during the day? ______________________________
Yes No Have you ever been told that you grind your teeth? ______________________________
Yes No Are you aware that some appointments will be during school/work hours? ______________________________
Yes No Female patients only: Are you pregnant? ______________________________

What is patient's attitude toward orthodontic treatment? ___________Very Motivated __________Will cooperate if needed________ Not motivated

All office visits are confirmed via email. Please provide the email address of the person(s) who wish to receive appointment confirmations (if available). You may register one or more email addresses per person:

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All email addresses are held in strictest confidence and will not be used for any other purpose.

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. Ulrich to perform a complete orthodontic evaluation.

Signature ______________________________ **Date** ______________