Medical History Form

1. Is the patient in good health? _____ Yes___ No___
2. Does the patient have any history of major illness? _____ Yes___ No___
3. Has the patient ever been under the care of a physician for illness? _____ Yes___ No___
4. Please list (if yes): _____
5. Circle any of the following for which the patient has been treated:

Diabetes	Tuberculosis	Endocrine Problems
Pneumonia	Anemia	Prolonged Bleeding
Heart Trouble	Epilepsy	Fainting or Dizziness
Rheumatic Fever	Asthma	Nervous Disorders
Bone Disorders	Kidney Involvement	Liver Involvement

6. Does the patient have tendency to colds _____ sore throats _____ ear infections _____?
7. Have tonsils and adenoids been removed?_____ What age?_____
8. List any allergies or drug sensitivities:_____
9. Are you currently taking any medications? Yes____ No____
10. Please list (if yes): _____
11. Has the patient reached puberty?_____
12. Girls: Has she started menstruation / Boys: Has his voice changed?_____
13. Height:_____ Weight:_____
14. Has there been any injuries to the face, mouth, or teeth? Yes_____ No_____
15. Has the patient ever sucked a thumb or fingers? Yes_____ No_____ Until what age?_____
16. Does the patient have any speech problem? Yes_____ No_____
17. Is the patient a mouth breather? Yes_____ No_____ While asleep?___ While awake?____
18. Have you been informed of any missing or extra permanent teeth? Yes_____ No_____
19. Has an orthodontist been consulted previously? Yes_____ No_____
20. Has either parent had orthodontic treatment? Yes_____ No_____
21. Reason for consultation:_____

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