MEDICAL AND DENTAL HISTORY

Your answers to the following questions are extremely important for an accurate diagnosis.
Thank you for your patience in answering the following questions.

General Dentist Name____

	YES	NO
Have you recently (within the past year) received treatment from a medical professional? For What? _______________________	□	□
Is patient on medication? Please Name It_______________________	□	□
Have you ever had Heart Disease? _______________________	□	□
Diabetes? _______________________	□	□
Asthma? _______________________	□	□
Allergies? _______________________	□	□
Convulsions? _______________________	□	□
Prosthetic Joint Replacement? _______________________	□	□
Hepatitis? _______________________	□	□
Prolong Bleeding? _______________________	□	□
Any Other Problems? (List) _______________________	□	□
Has any member of your family had orthodontic treatment? Relationship to patient_______________________	□	□
Ever habitually sucked your thumb, fingers, lips, or Tongue?	□	□

What is patients *attitude* toward wearing orthodontic appliances?

□ Eagerness? □ Complacency? □ Unwillingness?

T.M.J. and Facial Questionnaire

	YES	NO
1. Does your jaw make noise so that it bothers you or others?	□	□
2. Does your jaw get stuck so that you cannot open/close freely?	□	□
3. Does it hurt when you chew or open wide to take a big bite?	□	□
4. Do you have any jaw pain upon waking in the morning?	□	□
5. Have you ever been hit in the jaw (trauma)?	□	□
6. Have you ever been treated for a jaw muscle or jaw joint disorder?	□	□
7. Do you clench or grind your teeth?	□	□

I understand that the information I have given is correct to the best of my knowledge. All information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform the necessary dental services myself/my child may need.

____

Signature Date

I authorize the dental staff to use my/my child's photos for social media networking to show patient progress or for practice promotion. (Facebook, Website, etc.)

____

Signature Date

For existing patients only:____

I certify there has been no change in Dental or Medical History

Initial _______________ *Date*________________