

Grafton Orthodontics, S.C.

Amanda Olejniczak, D.D.S., M.S.

101 Falls Road • Suite 504 • Grafton, WI • 53024
(262)377-8950

MEDICAL HISTORY

Date _____

Patient's Date of Birth _____

Patient's Name _____

Home Address _____

Patient's Dentist _____

Patient's Physician _____

1. Is the patient under a physician's care at this time? Y N
If yes, why? _____
2. Does the patient have a history of any major illnesses? Y N
If yes, please explain _____
3. Is the patient taking any medications on a regular basis? Y N
If yes, why? _____
4. Is the patient allergic to any drugs (such as penicillin)? Y N
If yes, which drugs? _____
5. Does the patient have hay fever or any other allergies? Y N
Please name _____
6. Does the patient wear contact lenses? Y N
7. Has the patient had chronic tonsillitis? Y N
Has the patient had his/her tonsils or adenoids removed? Y N
When? _____
8. Does the patient snore in their sleep? Y N
9. Does the patient breathe through his/her mouth to a GREAT extent? Y N
10. Has the patient ever been diagnosed for any of the following? Please check where appropriate.

<input type="checkbox"/> ADHD	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Prolonged bleeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Psychological problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Liver problems	
<input type="checkbox"/> Endocrine/Thyroid	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Malignancies	

DENTAL HISTORY

1. When did the patient last visit his/her dentist? _____
2. Has the patient been to an orthodontist before? Y N
3. Has the patient ever been hit in the face or teeth? Y N
4. Does the patient have many fillings? Y N
5. Do the patient's gums bleed when they brush them? Y N
6. Does it hurt the patient to chew? Y N
7. Does it hurt the patient to open wide? Y N
8. Does the patient's jaw ever click, pop, or make a grinding noise? Y N
9. Has the patient's jaw ever "locked" or slipped out of place? Y N
10. Does the patient ever clench or grind your teeth? Y N
11. Are the patient's teeth sore or sensitive? Y N
12. Does the patient frequently experience any of the following?
 - a. Headaches Y N e. Face pain Y N
 - b. Neck pain Y N f. Eye pain Y N
 - c. Jaw pain Y N g. Other _____
 - d. Ear pain Y N

IF YOU HAVE ANSWERED "YES" TO QUESTION 12, PLEASE CONTINUE:

Which side hurts?

_____Right _____Left _____Both

How long has the patient had these symptoms?

_____Years _____Months _____Days

Would the patient explain the pain as:

Constant	Y	N
Aching	Y	N
Shooting	Y	N
Burning	Y	N
Stabbing	Y	N
Electrical	Y	N
Other _____		

Is the patient's pain worse in:

_____Morning
_____Afternoon/Evening
_____Anytime

Signature _____