Grafton Orthodontics, S.C.

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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.

_____ADHD/ADD	_____ Epilepsy	_____HIV positive	_____Prolonged bleeding
_____Anemia	_____ Eating Disorders	_____High blood pressure	_____Psychological problem
_____Asthma	_____Fainting	_____Hypoglycemia	_____Rheumatic Fever
_____Bone Disorders	_____Glaucoma	_____Kidney trouble	_____Tuberculosis
_____Diabetes	_____Heart trouble	_____Liver problems	
_____Endocrine/Thyroid	_____Hepatitis	_____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_____