Grafton Orthodontics, S.C.

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MEDICAL HISTORY

Date_____

Name_____ Gender_____

Dentist_____

Physician_____

1. Are you under a physician's care at this time? **Y** **N**
   If yes, why? _____
_____

2. Do you have a history of any major illnesses? **Y** **N**
   If yes, please explain_____
_____

3. Are you taking any medications on a regular basis? **Y** **N**
   If yes, why? _____
_____

4. Are you allergic to any drugs (such as penicillin)? **Y** **N**
   If yes, which drugs? _____
_____

5. Do you have hay fever or any other allergies? **Y** **N**
   Please name_____
_____

6. Do you wear contact lenses? **Y** **N**
7. Have you had chronic tonsillitis? **Y** **N**
   Have you had your tonsils or adenoids removed? **Y** **N**
   When? _____
8. Do you snore in your sleep? **Y** **N**
9. Do you breathe through your mouth to a GREAT extent? **Y** **N**
10. Have you ever been diagnosed for any of the following? Please check where appropriate.

_____ADHD	_____ 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	

Any additional medical concerns:
_____

***PLEASE SEE BACKSIDE →

DENTAL HISTORY

1. When did you last visit your dentist?_____
2. Have you been to an orthodontist before? **Y** **N**
3. Have you ever received a blow to the face or teeth that caused an injury? **Y** **N**
4. Do you have any fillings? **Y** **N**
5. Do your gums bleed when you brush them? **Y** **N**
6. Does it hurt you to chew? **Y** **N**
7. Does it hurt you to open wide? **Y** **N**
8. Does your jaw ever click, pop, or make a grinding noise? **Y** **N**
9. Has your jaw ever "locked" or slipped out of place? **Y** **N**
10. Do you ever clench or grind your teeth? **Y** **N**
11. Are your teeth sore or sensitive? **Y** **N**
12. Do you 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 ANY PART OF QUESTION 12, PLEASE CONTINUE:

Which side hurts?

_____Right _____Left _____Both

How long have you had these symptoms?

_____Years _____Months _____Days

Would you explain the pain as:

Constant	Y	N
Aching	Y	N
Shooting	Y	N
Burning	Y	N
Stabbing	Y	N

Other_____

Is the pain worse in:

_____Morning
_____Afternoon/Evening
_____Anytime

Signature_____