

Anemia	Yes _____ No _____	Herpes	Yes _____ No _____
Arthritis	Yes _____ No _____	Hives or Rash	Yes _____ No _____
Asthma	Yes _____ No _____	HIV Infection	Yes _____ No _____
Bone Disorder	Yes _____ No _____	Hyperactivity	Yes _____ No _____
Cancer	Yes _____ No _____	Immune System Disorder	Yes _____ No _____
Cardiovascular Disease	Yes _____ No _____	Inflammatory Rheumatism	Yes _____ No _____
Cerebral Palsy	Yes _____ No _____	Injury to Face/Head	Yes _____ No _____
Chest Pains	Yes _____ No _____	Jaundice	Yes _____ No _____
Developmental Disorder	Yes _____ No _____	Joint Problems	Yes _____ No _____
Diabetes	Yes _____ No _____	Kidney Disease	Yes _____ No _____
Digestive Disorders	Yes _____ No _____	Liver Disease	Yes _____ No _____
Emphysema	Yes _____ No _____	Low Blood Pressure	Yes _____ No _____
Endocrine Problems	Yes _____ No _____	Lung Disease	Yes _____ No _____
Epilepsy/Seizures	Yes _____ No _____	Neurological Disorder	Yes _____ No _____
Fainting/Dizziness	Yes _____ No _____	Nervous Disorder	Yes _____ No _____
Glaucoma	Yes _____ No _____	Pneumonia	Yes _____ No _____
Hayfever	Yes _____ No _____	Rheumatic Fever	Yes _____ No _____
Headaches	Yes _____ No _____	Stroke	Yes _____ No _____
Ear Problems	Yes _____ No _____	Tuberculosis	Yes _____ No _____
Heart Condition	Yes _____ No _____	Tumors	Yes _____ No _____
Heart Murmur	Yes _____ No _____	Ulcers Oral/Stomach	Yes _____ No _____
Hepatitis	Yes _____ No _____	Venereal Disease	Yes _____ No _____
Other	Yes _____ No _____		

If you have answered "yes" to any of the above, please specify: _____

Other illness: _____

Is the patient receiving any medication?	Yes _____ No _____
Is the patient allergic to any medication?	Yes _____ No _____
Is the patient allergic to anything else?	Yes _____ No _____

If "yes," please specify: _____

Does the patient need to take antibiotics before routine dental procedures?	Yes _____ No _____
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If "yes," please specify and give reason for use: _____

PATIENT BEHAVIOR

Progress in school:

_____ Behind children of the same age.
 _____ Same level as children of the same age.
 _____ Advanced beyond children of the same age.

Has the patient ever had psychiatric/psychological therapy?	Yes _____ No _____
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DENTAL HISTORY

Patient's dentist _____ Date of last dental examination _____

Has the patient been seen by any other dental specialist? Yes _____ No _____
If "yes," who? _____

Has there been any injury or trauma to the teeth or mouth? Yes _____ No _____
If "yes," please specify: _____

Has the patient ever had an unfavorable dental experience? Yes _____ No _____

Has the patient ever had speech problems/therapy? Yes _____ No _____

Has there been a previous orthodontic consultation/treatment? Yes _____ No _____

Has any family member had orthodontic treatment? Who _____ Yes _____ No _____

Has the patient ever sucked thumb/fingers? Until what age? _____ Yes _____ No _____

Is the patient a mouth breather? Asleep _____ Awake _____ Yes _____ No _____

Does the patient have any extra or missing permanent teeth? Yes _____ No _____

Has the patient ever had pain, clicking, or other noises in the jaw or temporomandibular joint? Yes _____ No _____

Does the patient have bleeding gums or sensitive teeth? Yes _____ No _____

Does the patient grind his/her teeth at night? Yes _____ No _____

Does the patient bite his/her fingernails? Yes _____ No _____

Does the patient play a musical instrument? Yes _____ No _____

Does the patient think the teeth are affecting his/her general health in any way? Yes _____ No _____

Is there dissatisfaction with the appearance of the teeth? Yes _____ No _____

Is the patient worried about having orthodontic treatment? Yes _____ No _____

Does the patient have difficulty chewing food? Yes _____ No _____

Has the patient ever had a reaction to a dental anesthetic? Yes _____ No _____

Has the patient ever had surgery or x-ray treatment for a tumor or growth on the lips or mouth? Yes _____ No _____

Does the patient have a toothache? Yes _____ No _____

Does the patient have frequent cold or canker sores? Yes _____ No _____

Has the patient ever had a severe sore or infection in the mouth? Yes _____ No _____

Is it difficult for the patient to open his/her mouth wide? Yes _____ No _____

Has the patient ever had extractions of one or more teeth? Yes _____ No _____

Has the patient ever had periodontal (gum) treatment? Yes _____ No _____

Has the patient had treatment to change/adjust the bite? Yes _____ No _____

Has the patient had treatment for TMJ (jawjoint) problems? Yes _____ No _____

If "yes" to any of the above, please specify: _____

Is the patient aware of an orthodontic problem? Yes _____ No _____

The patient's interest in orthodontic treatment is:

- _____ Wants treatment
- _____ Willing if treatment is necessary
- _____ Unwilling

What is the main reason you are seeking orthodontic treatment? _____

To the best of my knowledge, the above statements are complete and correct. No information has been omitted or withheld.

Signature of parent or guardian

Date