PATIENT NAME | DATE OF BIRTH / / | AGE

IS PATIENT CURRENTLY UNDER A PHYSICIAN'S CARE (OTHER THAN ROUTINE CARE)?
☐ YES ☐ NO IF YES, FOR WHAT REASON: Physician's Name_____

HAS PATIENT BEEN HOSPITALIZED?
☐ YES ☐ NO IF YES, FOR WHAT REASON:

List all medications prescribed by the patient's physician (including birth control pills), vitamins, herbal supplements, natural products, over-the-counter drugs taken routinely and controlled substances including dosages, if available.

ALLERGIES / SENSITIVITIES:

Is the patient allergic / sensitive (or ever had an adverse reaction) to: *Check all that apply or check none*

☐ Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Metals ☐ LATEX ☐ Nickel
☐ Aspirin ☐ Other Antibiotics ☐ Other Medications or Substances ☐ **NONE**

If yes, what type and extent of reaction

	YES	NO
1 Artificial (prosthetic) heart valve	☐	☐
2 Previous infective endocarditis	☐	☐
3 Damaged valves in transplanted heart	☐	☐
4 Congenital heart disease (CHD)		
Unrepaired, cyaotic CHD	☐	☐
Repaired (completely) in last 6 months	☐	☐
Repaired CHD with residual defects	☐	☐
5 Heart Disease/Surgery	☐	☐
6 Heart murmur	☐	☐
7 Heart pacemaker	☐	☐
8 Rheumatic Fever/heart disease	☐	☐
9 Mitral Valve Prolapse	☐	☐
10 High/low blood pressure	☐	☐
11 Learning Disability	☐	☐
12 Mental Health Disorder	☐	☐
13 Anorexia	☐	☐
14 Bulimia	☐	☐
15 Lung disease/COPD	☐	☐
16 Tuberculosis	☐	☐
17 Asthma	☐	☐
18 Shortness of Breath	☐	☐
19 Respiratory Ailments	☐	☐
20 Emphysema	☐	☐
21 Sinus Trouble	☐	☐
22 Diabetes Type I or II	☐	☐
23 Thyroid Problems	☐	☐
24 Persistent swollen glands	☐	☐
25 Kidney Problems	☐	☐
26 Venereal Disease	☐	☐
27 HIV Positive / AIDS / ARC	☐	☐
28 Alcohol Addiction	☐	☐
29 Drug Dependency	☐	☐
30 Chemical Dependency	☐	☐
31 Blood Disorders	☐	☐
32 Anemia	☐	☐
33 Leukemia	☐	☐
34 Prolonged Bleeding	☐	☐
35 Hemophilia	☐	☐
36 Sickle Cell Disease	☐	☐
37 Cancer	☐	☐
38 Tumors	☐	☐
39 Chemotherapy	☐	☐
40 Radiation Therapy	☐	☐
41 Neurological Disorders	☐	☐
42 Epilepsy	☐	☐
43 Stroke	☐	☐
44 Arthritis / Rheumatism	☐	☐
45 Autoimmune Disease	☐	☐
46 Artificial Joint / Prosthesis	☐	☐
47 Liver Disease	☐	☐
48 Hepatitis (circle one) Type A B C Other	☐	☐
49 Ulcers	☐	☐
50 Gastrointestinal Disease	☐	☐
51 GERD (gastic reflux)	☐	☐
52 Hearing Impaired	☐	☐
53 Glaucoma	☐	☐
54 Cortisone Medication	☐	☐
55 Fainting Spells	☐	☐
56 Organ Transplant	☐	☐
57 Removal of Spleen	☐	☐
58 Osteoporosis	☐	☐
59 Sleep Disorder	☐	☐
60 Is the Patient Pregnant	☐	☐
61 Premedication required for dental work	☐	☐

BISPHOSPHONATES

Has the patient ever taken any of these medications; alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** or Paget's disease? ☐ YES ☐ NO

Has the patient ever been treated or scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ YES ☐ NO

Date Treatment Began _____/_____/_____

61 Does the patient experience headaches, neck aches, especially under stress?	Yes	No	Sometimes
62 Does the patient grind or clench teeth?	Yes	No	Sometimes
63 Has the patient had any pain/tenderness in the jaw joints? (TMD/TMJ)	Yes	No	Sometimes
64 Does the patient have any clicking, popping or pain while chewing or eating?	Yes	No	Sometimes
65 Has the patient ever consulted anyone regarding a jaw problem?	Yes	No	
66 Has the patient had any jaw or head injuries?	Yes	No	
67 Have any teeth been injured due to an accident or fall?	Yes	No	
68 Has the patient been treated for periodontal disease or has treatment been recommended?	Yes	No	
69 If patient is a child, do they have a speech problem?	Yes	No	N/A
70 If patient is a child, does he/she have a persistent thumb or finger habit?	Yes	No	N/A
71 If patient is a child, has puberty been attained?	Yes	No	N/A

DR COMMENTS

I understand that the above information is necessary to provide me/my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or my child's health or medication.

Signature _____ Date _____
(PATIENT / PARENT / GUARDIAN)

Orthodontists Signature _____ Date _____

NAME _____ **#** _____

MEDICAL/DENTAL HISTORY