



440 East Marshall Street
 Suite 301
 West Chester, PA 19380
 610-918-3200 Fax: 610-918-2662

PATIENT NAME _____

MEDICAL HISTORY

Physician _____ **Phone** _____

General Health / Present Medications _____

List any Allergies (food, latex, metal and any drugs or medications) _____

Have you been diagnosed with or treated for any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding History	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Damage Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Condition need Pre-medication?
<input type="checkbox"/>	<input type="checkbox"/>	Are you Pregnant? N/A	<input type="checkbox"/>	<input type="checkbox"/>				

DENTAL HISTORY

Patient's Dentist _____ **Phone** _____

Complete Address _____ **Date of Last Visit** _____

- 1) Have you previously consulted an orthodontist? **Yes** **No**
 If yes, when? _____
- 2) Is there a family history of congenitally missing teeth? **Yes** **No**
 Yourself _____ Relative(s) _____
- 3) Do your gums bleed when you brush your teeth **Yes** **No**
- 4) Is any part of your mouth sensitive to temperature? **Yes** **No**
 Is any part of your mouth sensitive to pressure **Yes** **No**
- 5) Have you ever sucked your thumb or finger(s) **Yes** **No**
 If so, have you stopped this habit? _____ When? _____
- 6) Do you breathe predominantly through your mouth? **Yes** **No**
- 7) Have you had tonsils/adenoids removed? **Yes** **No**
 If yes, when? _____
- 8) Do you clench or grind your teeth during the day? **Yes** **No**
- 9) Do you clench & grind during the night? **Yes** **No**
- 10) Do you now have (ever had) pain in your jaw joint
 or in the sides of your face (in & about the ears)? **Yes** **No**
- 11) Have you ever had clicking or popping in your jaw joint? **Yes** **No**
- 12) Have you ever experienced pain when opening wide? **Yes** **No**
- 13) Have you had any injury to your jaw? **Yes** **No**
 If Yes, please explain _____
- 14) Have you had any injury to your teeth **Yes** **No**
 If Yes, please explain _____