

KAY & McCULLUM ORTHODONTICS

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PATIENT'S NAME _____ DATE OF BIRTH _____

MEDICAL/DENTAL HISTORY

YES NO

1. Have you been under the care of a physician at any time in the past two years? _____
2. Are you currently taking any medication?
If yes, what medication(s) are you taking? _____
3. Have you had or are you under treatment for any heart problems, rheumatic fever, heart murmur or high blood pressure? _____
4. Do you require antibiotic premedication for any reason, such as rheumatic fever? _____
5. Are you allergic to Penicillin or any drugs or medications? _____
6. Have you ever taken or are you currently taking any drugs as chemotherapy or for the treatment of Osteoporosis? _____
7. Check any of the following conditions which you have had:
1. Hepatitis 3. Arthritis 5. Diabetes 7. Other Please explain
2. Jaundice 4. Asthma 6. Allergies _____
8. Do you have a recent or current history of any infectious diseases?
If so, explain _____
9. Have you had your tonsils and/or adenoids removed? _____
10. Do you have difficulty breathing through your nose? _____
11. Have you ever had any accidents involving your face or teeth, such as a blow to the face, a car accident or fall? _____
12. For females: are you pregnant? _____
13. When did you last visit a dentist? _____
The dentist's name: _____
14. Have you ever had periodontal (gum) treatment? How long ago? _____
Describe the treatment _____
15. Do you clench or grind your teeth? _____
16. Do you have clicking, popping or grating noise in your jaw when chewing or opening?
Does it bother you? _____ How long have you had it? _____
17. Has your jaw ever locked? _____
18. What would you like to change about your teeth or smile? _____

COMMENTS: _____

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SIGNATURE _____ DATE _____

Title or relationship if patient is a minor _____