KAY ORTHODONTICS

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MEDICAL/DENTAL HISTORY

Patient Name _____ **DOB** ____/____/____

	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____ 2. Jaundice____ 3. Arthritis____ 4. Asthma ____ 5. Diabetes____ 6. Allergies____ 7. Other (please explain) _____		
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? _____ _____ _____		
I give permission for the use of photographs and records made in the process of examination, treatment, and retention for the purpose of research, education, and/or publication in professional journals.	___	___

_____ _____

Signature of Parent/Responsible Party Date