PATIENT MEDICAL HISTORY AND CONSENT FORM

DATE_____

PATIENT NAME_____SEX_____AGE_____

SCHOOL_____BIRTHDATE_____

NAMES/BIRTHDATES OF OTHER CHILDREN_____

MOTHER'S NAME_____FATHER'S NAME_____

PATIENT'S HOME ADDRESS_____
(Street) (City) (Zip Code)

HOME PHONE_____WORK PHONE_____
(Mother or Father)

PATIENT'S DENTIST_____

PATIENT'S PHYSICIAN_____

1. Is the patient in good health?..... YES NO

2. Is the patient currently under any medical treatment?.....YES NO
   If yes, please explain_____

3. Is the patient currently taking any drugs or medication?.....YES NO
   If yes, please list them_____

4. Has the patient had any adverse or allergic reaction to any drugs?.....YES NO
   If yes, describe reaction and name drug_____

5. Does the patient, or has the patient, had any cardiovascular related diseases such as rheumatic fever, heart murmur, heart attack, high or low blood pressure or any other disorder of the heart or blood vessels?.....YES NO
   If yes, please explain_____

6. Does the patient suffer from any respiratory problems such as asthma, emphysema, shortness of breath, allergy or tuberculosis?..... YES NO
   If yes, please explain_____

7. Does the patient have any blood disorders such as sugar diabetes, anemia, hemophilia or prothrombin deficiency?.....YES NO
   If yes, please explain_____

8. Does the patient exhibit any eye, ear, nose or throat disorder?..... YES NO
   If yes, please explain_____

9. Has the patient ever had hepatitis or mononucleosis?..... YES NO

10. Has the patient received advice or treatment for epilepsy, fainting, convulsions, frequent headaches or dizziness?.....YES NO

11. Has the patient suffered from recurrent indigestion, jaundice, colitis, ulcers or any other disorder of the stomach, intestines, kidneys, liver or gall bladder?..... YES NO
If yes, please explain_____

12. Have tonsils or adenoids been removed?.....YES NO

13. Are there any of the following habits: thumbsucking, finger-sucking, lipsucking, nail/lip biting, other?..... YES NO
If other, explain_____

14. Have there been any injuries to teeth such as falls, blows, chips, etc?..... YES NO

15. Has patient begun to voice change or menstruate?..... YES NO

16. Does the patient grind or clench the jaws at night?.....YES NO
During the day?.....YES NO

17. Does the patient breathe mainly through the mouth at night?..... YES NO
During the day?..... YES NO

18. Has anyone, including parents, had orthodontic treatment?..... YES NO

19 Is there any clicking or popping of the jaw at night?.....YES NO

20. Does any member of the family or close relative have a similar arrangement of teeth or appearance of jaws?.....YES NO

21. What Is the patient's attitude toward wearing orthodontic appliances?
Eagerness_____Willingness_____Complacency_____Resignation_____
Antagonism_____Other_____

22. Why Is the patient seeking treatment? Appearance_____Better Chewing_____
Better Speech_____Advice of a Dentist_____Advice of Friends_____Other_____
Please explain other_____

23. Are there any other problems associated with the patient's health that have not been covered on this medical history?.....YES NO
If yes, please explain_____

I,_____ Individually represent that all statements/answers
(Patient, if minor, Parent)
contained herein and in any medical history made a part hereof, are to the best of my knowledge and belief, complete, true and correctly recorded and it Is agreed that Dr. DiFranco and his staff et. al. shall not be presumed to have knowledge of any information not so recorded.

DATE_____

PATIENT_____
(Parent, if Patient is a Minor)