MEDICAL AND DENTAL HISTORY

Patient Name: ___________________________________
Answers to the following questions are for our records only and will be kept confidential.

MEDICAL HISTORY

Do you have, or have you had any of the following? Please mark the appropriate answers.
YesNoYesNoYesNoYesNoHeart problems/murmurDiabetesMeaslesSpeech/hearing disorderHigh blood pressureKidney problemsMumpsLearning disorderLow blood pressureLiver disordersChicken poxAutismCirculatory problemsHepatitisTuberculosisPsychiatric careAnemiaAsthmaTonsilitisHeadachesBleeding disorderArthritisSinus problemsEpilepsy or seizuresHemophiliaStrokeUlcerOsteoporosisProsthetic heart valveRheumatic FeverAIDS / HIVOsteopeniaPacemakerScarlet FeverSTDAllergies (list below)List any allergies:
____
List any drugs or medications you are taking:
____
Notes:____
____
____

Are you pregnant?	_____ Yes _____ No	
Do you smoke or chew tobacco?	_____ Yes _____ No	
Have you previously consulted an orthodontist?	_____ Yes _____ No	

CHILDREN UNDER TWELVE

Has the patient ever sucked a thumb or fingers?	_____ Yes _____ No	If so, until what age? ______
Does the patient breathe through the mouth while awake?	_____ Yes _____ No	
Or while asleep?	_____ Yes _____ No	
Does the patient snore?	_____ Yes _____ No	
Does the patient want his or her teeth straightened?	_____ Yes _____ No	

DENTAL HISTORY

Do you have, or have you had any of the following? Please mark the appropriate answers.

Yes	**No**		**Yes**	**No**		**Yes**	**No**	
		Dental pain			Congen itally missing teeth			Injury to mouth or face

		Bleeding gums			Extra permanent teeth			Jaw popping, clicking or pain
		Periodontal disease			Extracted permanent teeth			Difficulty chewing
		Grinding or clenching the teeth			Sores in mouth or lips			Speech problems

Notes:
____
____

Do you have a family history of missing teeth _____ Yes _____ No, or impacted teeth _____Yes _____No ?

Referred by ______________________________________	
Patient's dentist __________________________________	Date of last dental examination _________________
Patient's physician ________________________________	Date of last physical examination _______________
In case of emergency notify _________________________	Phone number (______) ________ - _____________
Nearest relative __________________________________	Phone number (______) ________ - _____________
Address ____	City ___________________ State ___ Zip _________
Responsible Party signature _________________________	Date ___________________
Doctor's signature ________________________________	Date ___________________

* Please save and email frontdesk@hogganortho.com when complete.