

HEALTH HISTORY

Patient Information

Patient Name _____ Birthdate _____
SS# _____ Today's Date _____

Medical History

Physician's Name _____ Date of last exam _____

Is patient under physician's care?-----Yes _____ No _____

Is patient receiving any medications?-----Yes _____ No _____

Does patient have any allergies?-----Yes _____ No _____

If so, please list: _____

Is the patient pregnant or suspect the possibility of being pregnant?----Yes _____ No _____

Has the patient ever had an unusual reaction to any drug such as penicillin or a local anesthetic?-----Yes _____ No _____

If yes, please list: _____

Has patient ever been treated for any of the following: (please circle

Rheumatic fever	Diabetes	Asthma
Heart defect	Bone Disorders	Tuberculosis
Heart murmur	Anemia	Hepatitis
High blood pressure	Prolonged Bleeding	Jaundice
Kidney Involvement	Fainting or dizziness	Epilepsy
Venereal Disease	Endocrine problems	Chronic sinus problems
Emotional concerns/Psychiatric Care		
Aids or Aids related complex		

Has the patient had tonsils or adenoids removed?-----Yes _____ No _____

Has patient had major surgery?-----Yes _____ No _____

List any other pertinent medical problems: _____

Dental History

Name of Dentist _____ Date of last exam _____

How often per day does patient brush? _____

Are additional appointments scheduled or planned with patient's dentist? Yes _____ No _____

Has patient ever received a severe blow to the teeth, jaw, neck?-----Yes _____ No _____

Has patient ever been diagnosed/suspected of having TMJ dysfunction?----Yes _____ No _____

Does patient have frequent cold sores or blister in the mouth?-----Yes _____ No _____

Does patient have any problems with sore gums or loosening of permanent teeth? Yes _____ No _____

Has patient ever consulted or received treatment from a periodontist?-----Yes _____ No _____

Does patient have any of the following habits: (circle all that apply)

Thumb or finger sucking	Grinding or clenching teeth
Mouth breathing	Nail biting

Has the patient ever had speech therapy? ----- Yes _____ No _____

Has the patient been informed of any missing or extra permanent teeth?--- Yes _____ No _____

Is the patient/parent concerned about the appearance of patient's teeth?--- Yes _____ No _____

Is patient/parent concerned with the function of teeth?-----Yes _____ No _____

Has patient ever had previous orthodontic treatment?-----Yes _____ No _____

Does patient want teeth straightened? -----Yes _____ No _____

Has any member of the family had orthodontic treatment?-----Yes _____ No _____

Does the patient's teeth or jaw characteristics resemble: (circle all that apply)

Father
Mother
Other Relative

----Continued on back----

Growth Information

(Adults may disregard this section)

Please fill out the following information concerning growing patients:

Patient Height: _____

Patient Weight _____

Has the patient grown in height in the last 12 months?----- Yes _____ No _____

Has the patients shoe size changed in the last 12 months?----- Yes _____ No _____

Does the growth rate seem: (circle one)

Accelerated

About the same

Slower than previous growth rate

Female patients: Has the patient started menstruating?----- Yes _____ No _____

If yes, approximate date: _____

Natural father's height: _____

Natural mother's height: _____

Older sibling(s) age and height _____

Comments you feel may be helpful:

Please be aware that some appointments will be scheduled earlier in the day and may infringe on work and school time. If there are any special scheduling requirements for the patient please advise us so we may work with you to schedule satisfactory appointments. Thank you.

Form completed by:

Relationship to the patient:

Date: _____

Steven R. Alexander, DDS, MS, PLLC