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GEORGE ORTHODONTICS
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Patient Medical History

PATIENT NAME _____

DATE OF BIRTH _____ AGE_____ SEX M ☐ F ☐

FREQUENCY OF DENTAL VISITS _____

PATIENT BRUSHES _____ TIMES PER DAY / WEEK / MONTH

ALLERGIES / DRUG SENSITIVITIES _____

SUCK(ED) THUMB OR FINGERS Y ☐ N ☐

IF YES, UNTIL WHAT AGE _____

ANY SPEECH PROBLEMS _____

PREVIOUS INJURIES TO MOUTH / FACE / TEETH Y ☐ N ☐

IF YES, EXPLAIN _____

MOUTH BREATHER Y ☐ N ☐

LIMITED MOUTH OPENING Y ☐ N ☐

TONGUE PAIN OR SWELLING Y ☐ N ☐

MISSING OR EXTRA TEETH Y ☐ N ☐

JAW ISSUES: ☐ CLICKING ☐ PAIN ☐ POPPING
☐ TMJ ISSUES ☐ LOCKING

ARE YOU / MIGHT YOU BE PREGNANT N/A ☐ Y ☐ N ☐

PLEASE LIST CURRENT MEDICATIONS

_____

_____

_____

WERE YOU ADVISED TO BE PREMEDICATED Y ☐ N ☐
IF YES, PLEASE EXPLAIN

_____

ARE YOU IN GENERALLY GOOD HEALTH Y ☐ N ☐

Do you have a history of any of the following?

DIABETES	Y ☐	N ☐
LATEX ALLERGY	Y ☐	N ☐
ADD / ADHD	Y ☐	N ☐
SEIZURES	Y ☐	N ☐
ASTHMA	Y ☐	N ☐
AIDS / HIV	Y ☐	N ☐
HEART PROBLEMS	Y ☐	N ☐
KIDNEY ISSUES	Y ☐	N ☐
HEPATITIS	Y ☐	N ☐
PROLONGED BLEEDING	Y ☐	N ☐
FAINTING / DIZZINESS	Y ☐	N ☐
BONE DISORDER	Y ☐	N ☐
ENDOCRINE / GROWTH ISSUES	Y ☐	N ☐
MENTAL HEALTH ISSUES	Y ☐	N ☐
SKIN DISORDER	Y ☐	N ☐
HAVE YOU EVER TAKEN BONE MEDICATION?	Y ☐	N ☐

IF YOU ANSWERED YES TO THE ABOVE, PLEASE EXPLAIN _____

_____

_____

_____

OTHER _____

_____

_____