STEVE WONG, D.D.S., M.S.

PRACTICE LIMITED TO ORTHODONTICS

MEDICAL - DENTAL HISTORY

PATIENT NAME _____ BIRTHDATE _____ DATE _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health.
This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

FAMILY PHYSICIAN: _____ PHONE NO. _____

CHECK YES OR NO

- ❑ YES ❑ NO Do you have any CURRENT HEALTH PROBLEMS? _____
- ❑ YES ❑ NO Are you under a PHYSICIAN'S CARE now? For what? _____
- ❑ YES ❑ NO Are you currently taking any medication? If yes, what? _____
- ❑ YES ❑ NO Have you had any major operations? If so, what? _____
- ❑ YES ❑ NO Are you allergic to any medications? _____
- ❑ YES ❑ NO Have you ever had any adverse response to any drugs including penicillin and aspirin?
- ❑ YES ❑ NO Have you ever had a serious accident involving head or jaw injuries?
- ❑ YES ❑ NO Have you received any donor organs, artificial heart valves, vessels, joint implants or use a pacemaker?
- ❑ YES ❑ NO Are you pregnant?
- ❑ YES ❑ NO Do you smoke?
- ❑ YES ❑ NO Are you on a diet at this time?
- ❑ YES ❑ NO Do you have any reason to suspect you are not in good health?
- ❑ YES ❑ NO Have any wounds healed slowly or presented other complications?
- ❑ YES ❑ NO Do you have a history of fainting?
- ❑ YES ❑ NO Have you ever had any X-RAY TREATMENTS (other than diagnostic)?
- ❑ YES ❑ NO Have you had BAD dental experiences in the past?
- ❑ YES ❑ NO Are you APPREHENSIVE about dental treatment?
- ❑ YES ❑ NO Have you had any PERIODONTAL (GUM) treatments?
- ❑ YES ❑ NO Do your gums BLEED or feel TENDER or IRRITATED?
- ❑ YES ❑ NO Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)
- ❑ YES ❑ NO Are you UNHAPPY with the APPEARANCE of your teeth?
- ❑ YES ❑ NO Are you aware of GRINDING or CLENCHING your teeth?
- ❑ YES ❑ NO Do you have HEADACHES, EARACHES or NECK PAINS?
- ❑ YES ❑ NO Do you have LOOSE, TIPPED or SHIFTING teeth (circle)
- ❑ YES ❑ NO Would you like your smile to LOOK BETTER or DIFFERENT?
- ❑ YES ❑ NO Do you REGULARLY use DENTAL FLOSS?

RECERTIFICATION: I certify that there have been no changes in my health except as noted below.

DATE	CHANGE	SIGNATURE

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

Heart Failure
Heart Disease or Attack
Angina pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joints (Hip, Knee)
Anemia
Stroke
Kidney Trouble
Ulcers
Cosmetic Surgery
H.I.V.
A.I.D.S.
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Fever Blisters
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Glaucoma
Chemotherapy (Cancer, Leukemia)
Veneral Disease (Syphilis, Gonorhea, etc.)
Bruise Easily
Emphysema
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
Cobalt Treatment
Arthritis
Rheumatism
Cortisone Medicine
Pain in Jaw Joints
Alcoholism
Bleeding Problems

ADDITIONAL COMMENTS: _____

- ❑ YES ❑ NO Has anyone in your family had orthodontic treatment?
  Name: _____ Orthodontist _____
- ❑ YES ❑ NO Does patient want orthodontic treatment?
- ❑ YES ❑ NO Has the patient had any previous orthodontic treatment?
  Name: _____ Orthodontist _____
- ❑ YES ❑ NO Has there been any previous orthodontic examination or consultation?
  Name: _____ Orthodontist _____

GROWTH INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE:

Father's Height _____ Mother's Height _____ Adopted: ❑ YES ❑ NO

Patient Resembles: ❑ Neither Parent ❑ Mother ❑ Father Approximate increase in height in the last 6 months: _____ inches

Girl: Has she started menstruation? ❑ YES ❑ NO When? _____

Boy: Has his voice changed? ❑ YES ❑ NO When? _____

Name and ages of patient's brothers and sisters _____

CONSENT:

I understand that the information that I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental services that I may need with my informed consent. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time the services are rendered unless financial arrangements have been made.

Signature _____ Date _____ Orthodontist's Signature _____

(Parent of Child)