



## DENTAL HISTORY

Y N Does patient see dentist regularly?  
Date of last appointment \_\_\_\_\_

Y N Fluoride treatment in dental office?

Y N Fluoride drops or pills or fluoridated water?

Y N Has patient sucked thumb or fingers?  
Until what age? \_\_\_\_\_

Y N Has patient used pacifier?

Y N Is patient a mouth breather?

Y N Does patient clench or grind teeth?

Y N Speech problems or speech therapy?

Y N Difficulty chewing or swallowing?

Y N Were any teeth removed by extraction?  
Explain \_\_\_\_\_

Y N Has patient been informed of having missing or extra permanent teeth?

Y N Pain, clicking or popping when opening or closing mouth?

Y N Severe injuries to head or face?

Y N Head or neck pain?

Y N TMJ problems?

Y N Orthodontic treatment in the past?

Y N Other orthodontic consultations?

Y N Have any family members had orthodontic treatment? Who? \_\_\_\_\_

Y N Is patient adopted? At what age? \_\_\_\_\_

Y N Are you aware that some appointments will infringe on school/work time?

What concerns does the patient have about appearance or function of his/her teeth? \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Is patient currently under care of physician?  
If yes, for what? \_\_\_\_\_

Please rate patient's medical health.

Good Fair Poor

Y N Is patient taking prescription drugs?  
If yes, please list \_\_\_\_\_

Y N Is patient allergic to any drugs?  
If yes, please list \_\_\_\_\_

Y N Does patient need to be pre-medicated before dental treatment? Explain \_\_\_\_\_

Y N Has patient had adenoids or tonsils removed?

Y N Other operations or hospitalizations?  
If yes, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the patient ever had any of the following medical conditions or problems? If yes, please circle:

Heart Murmur

Hemophilia

Heart problems of any kind

Endocrine/growth problems

Rheumatic fever

Diabetes

Fainting/dizziness

HIV+/AIDS

Convulsions/epilepsy

Hepatitis

Hyperactivity

Allergies

Arthritis

Asthma

Please describe any other medical conditions not mentioned above \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest of confidence. I also understand that I will be assisted with insurance claims to obtain maximum benefits, but that I am directly responsible for payment for all services rendered by Ian P. Lennard, DDS, MS.

Signature of patient, parent or guardian \_\_\_\_\_ Date \_\_\_\_\_