Dr. Perry Do, DDS MS
MEDICAL HISTORY

Physician_____Date of Last Visit_____
Address_____Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations?_____
Yes No Ever been involved in a serious accident? _____
Yes No Has seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started?_____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has:
Abnormal bleeding/Hemophilia

Allergies	Diabetes	Heart Surgeries	Pneumonia
Anemia	Dizziness	Hepatitis/Liver problems	Prolonged Bleeding
Angina	Emphysema	Herpes	Psychiatric Treatment
Arthritis	Epilepsy	High Blood Pressure	Radiation Therapy
Artificial Joint	Fainting	HIV/AIDS	Rheumatic Fever
Asthma or Hay Fever	Fever Blisters	Immunosuppressed	Sinus Trouble
Bone Disorders	Gastrointestinal Disorders	Jaundice	Stroke
Cancer	Glaucoma	Kidney Problems	Thyroid Problems
Chemotherapy	Heart Attack	Lung Disease	Tuberculosis
Cold Sores	Heart Problems	Low Blood Pressure	Tumors
Congenital Heart Defect	Heart Murmur	Nervous/Mental Disorders	Venereal Disease

Has patient had any disease, serious illness/surgery, condition or problem not listed above? __ Yes __ No If yes, explain?
_____

DENTAL HISTORY

General Dentist_____Tel# _____ Date of last visit_____
What concerns you most about your teeth? _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning?_____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours?_____

To the best of my knowledge, I have completed every question completely and accurately. I will inform my orthodontist of any changes in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

_____ _____
Parent's Signature/Responsible Party for Minor Date