OAKLEY ORTHODONTICS

DATE_____

PATIENT'S MEDICAL HISTORY

Patient's Name_____Date of Birth_____Male ◯ Female ◯
Last First Middle

Patient's Physician_____ Physician's Phone_____

Has the patient had their tonsils or adenoids removed? Yes ◯ No ◯ If yes; date of surgery_____

Has the patient ever had an unusual reaction/allergy to a drug? Yes ◯ No ◯ If yes;_____

Does the patient have any known allergies to medications, food, etc? Yes ◯ No ◯ If Yes;_____

Is the patient under the care of a physician? Yes ◯ No ◯ If yes, please explain why_____

Does the patient have a speech problem? Yes ◯ No ◯ If yes, is the patient receiving therapy? Yes ◯ No ◯

Has the patient experienced any of the following?

Arthritis Yes ◯ No ◯	Nervous Disorder Yes ◯ No ◯	Frequent Colds Yes ◯ No ◯	Immune Deficiency Yes ◯ No ◯	Thyroid or Hormonal Problems Yes ◯ No ◯
Anemia Yes ◯ No ◯	Hyperactivity Yes ◯ No ◯	Allergies/Sinus Yes ◯ No ◯	Herpes Yes ◯ No ◯	Major Surgery Yes ◯ No ◯ _____ _____ _____
Excessive Bleeding Yes ◯ No ◯	Hepatitis Yes ◯ No ◯	Asthma Yes ◯ No ◯	Ulcers Yes ◯ No ◯	Serious Medical Problems Yes ◯ No ◯ _____
Epilepsy/Seizures Yes ◯ No ◯	Venereal disease Yes ◯ No ◯	Rheumatic Fever Yes ◯ No ◯	Heart Problems Yes ◯ No ◯	_____ _____ _____
	Diabetes Yes ◯ No ◯	Tuberculosis Yes ◯ No ◯		

PATIENT'S DENTAL HISTORY

Patient's General Dentist_____ Dentist's Phone_____

Does the patient presently suck their thumb or fingers? Yes ◯ No ◯
Does the patient breathe mostly through the mouth? Yes ◯ No ◯
Has the patient ever experienced an injury to the jaw or teeth? Yes ◯ No ◯
Does the patient grind or clench their teeth? Yes ◯ No ◯
Has the patient ever experienced clicking ◯, popping ◯, stiffness ◯, or soreness ◯ in the jaw or jaw muscles?
Has the patient ever experienced episodes of the jaw not opening or closing normally? Yes ◯ No ◯
Has the patient ever experienced pain or discomfort in the front of the ear? Yes ◯ No ◯
Has the patient ever experienced headaches, neck, or back pain? Yes ◯ No ◯ If Yes, please describe _____
Has the patient ever had orthodontic treatment or worn a retainer before? Yes ◯ No ◯
What is the patient or parent's primary concern/s?_____
_____

EMERGENCY CONTACT

Name of nearest relative not living with you_____

Telephone_____ Relationship to patient_____

I certify that the information on this form is complete and true to the best of my knowledge.

Patient/Guardian Signature_____ Date_____

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