

PATIENT INFORMATION

DENTIST _____ LAST SEEN _____

PHYSICIAN _____ LAST SEEN _____

MUSICAL INSTRUMENT _____

Do you (the patient) have any of the following habits?

- Y/N Thumb/Finger Sucking
Y/N Clenching/Grinding Teeth
Y/N Mouth Breather
Y/N Speech Problems
Y/N Nail Biting
Y/N Tongue Thrust
Y/N Does your jaw ever get "stuck, locked, or go out"?
Y/N Do you hear noises from the jaw joint, including clicking/popping?
Y/N Do you have pain in or about the ears or cheeks?
Y/N Do you have pain when chewing or yawning?
Y/N Does your bite feel uncomfortable?

Current Health: Good _____ Fair _____ Poor _____

List all medications/drugs currently taking, including birth control _____

List all allergies _____

Are you currently under the care of a physician? If yes, please give reason _____

Do you use tobacco products? _____

Do you (the patient) have a history of any of the following medical problems?

- | | | | |
|-----|---|-----|-----------------------------|
| Y/N | Heart Murmur/Defects | Y/N | Convulsions/Epilepsy |
| Y/N | Diabetes | Y/N | Hearing Impairment |
| Y/N | Cancer | Y/N | Kidney/Liver Problems |
| Y/N | Blood Transfusion | Y/N | Fainting/Dizziness |
| Y/N | HIV/ Aids | Y/N | Neurological |
| Y/N | Hepatitis | Y/N | Lyme Disease |
| Y/N | Mitral Valve Prolapse | Y/N | Handicap/Disabilities |
| Y/N | Hemophilia | Y/N | Dependency on Drugs/Alcohol |
| Y/N | Asthma | Y/N | Tuberculosis |
| Y/N | Rheumatic Fever | Y/N | Hypertension |
| Y/N | Has there been any injuries to the face, mouth, chin, or jaw? | | |
| Y/N | Have you been informed of any missing teeth or extra teeth? | | |
| Y/N | Have you ever been evaluated for orthodontic treatment? | | |