Medical History

Name ______________________________ **Physician**______________________________

How is your general health? Excellent ____ Good ____ Fair____ Poor____

Please check any of the medical conditions below that you have had or currently have:

____Abnormal bleeding/Hemophilia	____Diabetes	____HIV/AIDS	____Thyroid Problems
____ADD/ADHD	____Dizziness	____Hormone Disorder	____Tuberculosis
____Airway Problems	____Epilepsy	____Kidney Problems	____Tumor or Cancer
____Allergies Medicines/Latex	____Nervous Disorders	____Vision Problems	____Osteoporosis
____Anemia	____Heart Problems	____Pneumonia	____Prolonged Bleeding
____Arthritis	____Heart Murmur	____Radiation/Chemotherapy	____Respiratory Problems
____Asthma or Hay Fever	____Hepatitis/Liver Problems	____Rheumatic Fever	____Bone Disorders
____Congenital Heart Defect	____Gastrointestinal Disorders	____High/Low Blood Pressure	____Herpes

Are you pregnant?____Yes ____No

Are there any medical conditions we have not discussed that you feel we should be aware of?______________________________

____

Are you currently under medical treatment or taking any medication?_____Yes _____No

Please describe:____

Have you had any trauma to your head, neck, face or mouth regions? _____Yes _____No

Please Describe ____

Dental History

General Dentist______________________________ Date of last visit______________________________

What concerns you most about your teeth?____

Do you smoke or chew tobacco:______________________________ Any type of thumb or tongue habit?_____ Yes _____No

Have you ever noticed any noises (popping, clicking, grinding) in your jaw joint area? _____Yes _____ No

Have you ever had any pain in your jaw joint area? _____ Yes _____ No Is the patient a mouth breather? _____ Yes _____ No

Have you ever had an episode where you could not open or close your jaw? _____ Yes _____No

Do you have any dental treatment or fillings planned for the near future? _____ Yes _____ No

Have you ever been treated for periodontal (gum) disease? _____ Yes _____ No

Has the patient ever seen an orthodontist? _____Yes _____ No If yes, who and when ______________________________

Are you aware some appointments will be during school/work hours? _____ Yes _____ No

I,______________________________ , have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. White to perform a complete orthodontic evaluation.

Signature: ______________________________ Date:______________________________

WHITE ORTHODONTICS

20 Pidgeon Hill Drive, Suite 207 ♦ Potomac Falls, VA 20165 ♦ Ph/Fax 703.444.5337

www.WhiteOrthodontics.Net