reichheld ting orthodontics
ADULTS & CHILDREN

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MEDICAL/DENTAL HISTORY

Patient's Name: ____________________

Physician's Name: ____________________ Phone: __________

Dentist's Name: ____________________ Phone: __________

☐Yes ☐No Are you currently under any medical treatment? __________

☐Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw? __________

☐Yes ☐No Are you aware of either clenching or grinding of teeth? __________

☐Yes ☐No Do you have frequent headaches? How often? __________

☐Yes ☐No Do you have habits such as nail biting, finger or thumb sucking, lip or cheek biting? __________

☐Yes ☐No Do you have speech problems, or are you in speech therapy? __________

☐Yes ☐No Do you have a history of: ☐Joint swelling ☐Asthma ☐TB ☐AIDS ☐Kidney problems ☐Liver Condition ☐Epilepsy ☐Rheumatic Fever ☐Hepatitis ☐Other major illnesses? __________

☐Yes ☐No Do you bleed easily? __________

☐Yes ☐No Is there a tendency to faint or become dizzy? __________

☐Yes ☐No Do you have allergies? (Sulphur, penicillin, novocaine, etc.) __________

☐Yes ☐No Are you currently taking any medication? List: __________

☐Yes ☐No Do you have a heart condition? If yes, do you pre-medicate? ☐Yes ☐No Cardiologist name: __________

☐Yes ☐No Have you ever been diagnosed with any bone diseases such as Osteopenia, Osteoporosis or Paget's Disease? ____

☐Yes ☐No Are you currently or ever been treated for Osteopenia, Osteoporosis or Paget's Disease? __________

☐Yes ☐No Have you ever taken a bone building or strengthening medication such as Fosamax to reduce bone loss? ________

☐Yes ☐No Do you have sleep apnea? __________

☐Yes ☐No Is there a chance you may be pregnant? __________

☐Yes ☐No Do you smoke or chew tobacco? __________

☐Yes ☐No Have there been any injuries to the teeth? __________

☐Yes ☐No Have you had any permanent teeth extracted? __________

☐Yes ☐No Have we treated any other family members? If so, whom: __________

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in this patient's medical history or this patient's medication change, I will inform the doctor at my child's next appointment without fail.

Responsible Party's Signature: ____________________ Date: __________

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