

Grafton Orthodontics, S.C.

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MEDICAL HISTORY

Date _____

Date of Birth _____

Name _____

Home Address _____

Dentist _____

Physician _____

1. Are you under a physician's care at this time? **Y** **N**
If yes, why? _____

2. Do you have a history of any major illnesses? **Y** **N**
If yes, please explain _____

3. Are you taking any medications on a regular basis? **Y** **N**
If yes, why? _____

4. Are you allergic to any drugs (such as penicillin)? **Y** **N**
If yes, which drugs? _____

5. Do you have hay fever or any other allergies? **Y** **N**
Please name _____

6. Do you wear contact lenses? **Y** **N**

7. Have you had chronic tonsillitis? **Y** **N**
Have you had your tonsils or adenoids removed? **Y** **N**
When? _____

8. Do you snore in your sleep? **Y** **N**

9. Do you breathe through your mouth to a GREAT extent? **Y** **N**

10. Have you ever been diagnosed for any of the following? Please check where appropriate.

<input type="checkbox"/> ADHD	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Prolonged bleeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Psychological problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Liver problems	
<input type="checkbox"/> Endocrine/Thyroid	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Malignancies	

DENTAL HISTORY

1. When did you last visit your dentist? _____
2. Have you been to an orthodontist before? Y N
3. Have you ever received a blow to the face or teeth that caused an injury? Y N
4. Do you have many fillings? Y N
5. Do your gums bleed when you brush them? Y N
6. Does it hurt you to chew? Y N
7. Does it hurt you to open wide? Y N
8. Does your jaw ever click, pop, or make a grinding noise? Y N
9. Has your jaw ever "locked" or slipped out of place? Y N
10. Do you ever clench or grind your teeth? Y N
11. Are your teeth sore or sensitive? Y N
12. Do you frequently experience any of the following?
 - a. Headaches Y N
 - b. Neck pain Y N
 - c. Jaw pain Y N
 - d. Ear pain Y N
 - e. Face pain Y N
 - f. Eye pain Y N
 - g. Other _____

IF YOU HAVE ANSWERED "YES" TO QUESTION 12, PLEASE CONTINUE:

Which side hurts?

_____Right _____Left _____Both

How long have you had these symptoms?

_____Years _____Months _____Days

Would you explain the pain as:

Constant	Y	N
Aching	Y	N
Shooting	Y	N
Burning	Y	N
Stabbing	Y	N
Electrical	Y	N
Other _____		

Is the pain worse in:

_____Morning
_____Afternoon/Evening
_____Anytime

Signature _____