WAVESCAPE ORTHODONTICS: MEDICAL HISTORY FORM

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic care. All information will be kept completely confidential.

Name _____ Date of Birth:____/____/____

Name of School patient attends (if applicable) _____

Have any of the patients relatives attended our surgery? _____ Name of Relative_____

General Dentist _____ Medical Practitioner's name (Doctor) _____

Is the patient covered by health insurance? _____ If so, name of fund _____

Has the patient experienced any health problems? No ☐ Yes ☐ Explain_____

Any major change in the patient's health recently? No ☐ Yes ☐ Explain_____

Is the patient currently taking medications? No ☐ Yes ☐ Explain_____

Has the patient ever been hospitalized? No ☐ Yes ☐ Explain_____

Have the patient's tonsils/adenoids been removed? No ☐ Yes ☐ Explain_____

Does the patient have any physical or mental impairments? No ☐ Yes ☐ Explain_____

Has or is the patient currently undergoing speech therapy? No ☐ Yes ☐ Explain_____

Please tick if the patient has a history of any of the following conditions:

☐ Heart Murmur	☐ Haemophilia	☐ Tonsillitis	☐ Prolonged Bleeding
☐ Heart Surgery	☐ Blood Disease	☐ Frequent Headaches	☐ Hives/Rashes
☐ Rheumatic Fever	☐ Arthritis	☐ Bone disorders	☐ Nervous/Anxious
☐ Mitral Valve Prolapse	☐ Diabetes	☐ Development Disorders	☐ Tuberculosis
☐ Congenital Heart Disease	☐ Kidney Disease	☐ Mouth Breather	☐ Fainting Episodes
☐ Endocrine Disorders	☐ Thyroid Problems	☐ Herpes (Fever Blisters)	☐ Hepatitis
☐ Growth Disorders	☐ Cancer	☐ Allergies	☐ Asthma
☐ Liver Disease	☐ HIV	☐ Hay Fever	☐ Epilepsy

Does the patient clench/grind his/her teeth? No ☐ Yes ☐ When _____

Does the patient have a nail biting habit? No ☐ Yes ☐

Does the patient suck thumb or fingers? No ☐ Yes ☐ If stopped, at what age?_____

Has the patient ever had:

Jaw/joint pain?	No ☐ Yes ☐	jaw/joint locking?	No ☐ Yes ☐
Jaw/joint grating noises?	No ☐ Yes ☐	jaw/joint clicking?	No ☐ Yes ☐
Jaw/joint popping?	No ☐ Yes ☐	ringing in ears?	No ☐ Yes ☐

Since diagnostic x-rays may be indicated, in the case of a female patient is there presently a possibility of pregnancy? No ☐ Yes ☐

I certify that the above medical history is accurate at this time. If there are future changes, I will inform this office. I also authorize this office to examine and initiate necessary dental services in the case of a minor patient.

Signature _____ Date _____/_____/_____
Parent/Guardian