JEDIDIAH R. GASS, DDS, MSD, PC

Patient's Name _____

MEDICAL HISTORY

Patient's Physician _____ Date Last Seen _____

Yes	No	
☐	☐	Has the patient seen an ENT specialist, endocrinologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? (If yes, circle all that apply.)
☐	☐	Does the patient have a current medical problem? _____
☐	☐	Is the patient currently taking any pills, medications, or drugs? If yes, please list. _____
☐	☐	Is the patient currently taking bisphosphonates for osteoporosis or any other bone condition? (examples are, but not limited to, Fosamax, Actonel, Boniva, and Reclast)
☐	☐	Has the patient had an unusual reaction to any medication? _____
☐	☐	Has the patient ever had an injury to the head, face or mouth? _____
☐	☐	Has the patient ever had a serious illness? _____
☐	☐	Has the patient ever had any surgery or been hospitalized? _____
☐	☐	Has the patient had the tonsils or adenoids removed? _____ Age _____
☐	☐	Does the patient have any congenital (born with) problems? _____
☐	☐	Has the patient ever been diagnosed with a heart murmur? _____
☐	☐	Is the patient allergic to anything (foods, medications, etc.)? If yes, please list. _____

Has the patient ever been diagnosed or treated for any of the following (circle all that apply):

Diabetes	Anemia	Endocrine problem	Tuberculosis	AIDS or HIV
Allergies	Hepatitis	Recurrent pain	Bleeding disorder	Nervous disorder
Arthritis	Low/High Blood pressure	Emotional problem	Rheumatic fever	Liver problem
Ulcers	Communication disability	Breathing trouble	Joint replacement	Asthma
Cerebral Palsy	Learning disability	Heart condition	Multiple sclerosis	Growth disorder
Epilepsy	Prolonged bleeding	Pneumonia	Kidney problem	Other_____
Cancer	Fainting/Dizziness	Bone disease		

DENTAL HISTORY

Patient's Dentist _____ Date Last Seen _____

What is the main reason for seeking orthodontic treatment? _____

Yes	No	
☐	☐	Is the patient currently undergoing any dental treatment? _____
☐	☐	Is the patient currently taking any medications for dental reasons? _____
☐	☐	Has the patient had difficulty associated with dental treatment? _____
☐	☐	Has the patient seen a periodontist, endodontist or oral surgeon? _____
☐	☐	Has the patient had previous orthodontic treatment or consultation? _____ When? _____
☐	☐	Has the patient had any teeth extracted? Why? _____
☐	☐	Has the patient ever injured or broken any teeth? Explain. _____
☐	☐	Does the patient have any missing or extra teeth? _____
☐	☐	Does the patient have any difficulty eating, speaking or swallowing? _____
☐	☐	Does the patient have any habits such as thumb sucking or nail biting? _____
☐	☐	Does the patient have any dental or facial pain? _____
☐	☐	Does the patient's jaw joint make noises or hurt? _____
☐	☐	Has the patient's jaw ever locked open or closed? _____
☐	☐	Does the patient habitually grind or clench the teeth together? _____
☐	☐	Does the patient normally breath with the lips apart? _____
☐	☐	Is the patient aware of any swellings or growths in the mouth or face? _____
☐	☐	Is the patient especially concerned about orthodontic treatment? _____
☐	☐	Is there any other medical or dental information we should know? _____

Signature (Parent or guardian if patient is a minor) _____ Date _____

ORTHODONTICS

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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