THE SMILE RANCH ORTHODONTICS

BY ALAN C. JENSEN DDS MS

★ PATIENT HEALTH HISTORY ★

Patient's Name: _____ Date of Birth: _____

Gender: Male ___ Female ___ Name of School: _____ Grade: _____

Names and ages of children and siblings: _____

_____

Hobbies: _____ Sports: _____

Describe any injuries to the face, mouth or teeth? _____

Have you ever sucked your thumb or finger? _____ Until what age? _____

Describe any speech problems? _____

Do you grind or clench your teeth? _____ While awake? _____ While asleep? _____

Do you breath through your mouth? _____ While awake? _____ While asleep? _____

Are you aware of any missing or extra permanent teeth? _____

Any teeth removed by extraction? _____ Is there a tongue-thrust problem? _____

Describe any pain or clicking when opening mouth? _____

Have you consulted with an orthodontist before? _____

Name of family physician: _____ Phone: _____

Is patient currently under physician's care? _____ Reason: _____

List medications patient is currently taking: _____

List any allergies: _____

Please check if patient has had any of the following:

___ Adenoids removed	___ Aids	___ Allergies
___ Anemia	___ Arthritis	___ Artificial heart valves
___ Asthma Bone disorders	___ Bruxing	___ Cancer treatment
___ Cardiac pacemaker	___ Congenital heart lesions	___ Chronic cough
___ Diabetes	___ Ear problems	___ Emotional problems
___ Endocrine problems	___ Epilepsy	___ Faintness/Dizziness
___ Headaches (frequent)	___ Heart Murmur	___ Heart trouble
___ Hepatitis	___ Herpes	___ High blood pressure
___ HTLV-III virus	___ Jaundice	___ Joint swelling
___ Kidney treatment	___ Organ transplant	___ Osteoporosis
___ Prolonged bleeding	___ Psychiatric treatment	___ Rheumatic fever
___ Scoliosis	___ Shortness of breath	___ Sinus trouble
___ Stroke	___ Swelling of ankles	___ TMJ
___ Thyroid problems	___ Tonsils removed	___ Tuberculosis
___ Venereal disease	___ Whiplash	

Please list any other serious illness: _____

_____

Signature (Parent Signature if Minor): _____ Date: _____

Confidential (for record and pre-treatment evaluation) **Thank you for supplying the above information**