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WELCOME TO OUR ORTHODONTIC PRACTICE!

We'd appreciate it if you could please complete this medical/dental questionnaire.

YOUR NAME: _____

DENTIST NAME: _____

1. Are you currently under the care of a medical practitioner or taking any medication at present. Please discuss and list medications:
   _____

2. Please tick if you have had any of the following:

MEDICAL

_____ A heart disorder/murmur
Infective endocarditis
_____ Bleeding disorder
_____ Diabetes
_____ Asthma
_____ Rheumatic Fever
_____ Tonsils/Adenoids removed
_____ Aids/related disease
_____ Thyroid Problem
_____ Hepatitis
_____ Are you pregnant?

DENTAL

_____ Sucked thumb as a child.
_____ Periodontal (gum) disease
_____ Had Root Canal Treatment
_____ HAVE ANY PERMANENT TEETH:
___ Been extracted Including Wisdom Teeth
____ Been injured/chipped
____ Not appeared

Any other illness/disablilty:_____
List any allergies: _____

3. Have you had any pain in the jaw or clicking?
   If so please discuss: _____
4. Have you ever had speech therapy? _____Yes _____No
5. Have you inherited a family likeness in facial characteristic? If so please explain:_____

6. What is your main concern in seeking this appointment?
   _____
7. To whom may we thank for referring you to our practice? _____

If you subsequently develop any illness please keep us informed.

THANK YOU FOR PROVIDING US WITH THIS INFORMATION

SIGNATURE:_____Date:_____

Address: …….

Phone:…….Mobile……E-mail……