Pure Smiles
ORTHODONTICS

## MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____

## DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth?_____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches?_____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some hobbies or interests _____
Female Patients only:
Yes No Are you pregnant?_____
Yes No Has menstruation started? _____
Yes No Are you currently taking or have been given intravenous biophosponates for serious bone cancers, such as zometa or Aredia?_____
Yes No Are you currently taking or have been given oral or intravenous biophosponates for osteoporosis, osteopenia or other such as Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel, or Bonefos? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Silvana Gonzalez to perform a complete orthodontic evaluation.

Signature: _____ Date: _____