Medical History

Physician's name_____ Phone number_____

Please describe patient's current physical health: Good [ ] Fair [ ] Poor [ ]
Is patient currently under the care of a physician? Yes [ ] No [ ]
If yes, for what condition: _____

Please list all medications patient is currently taking: _____

Please list all medications patient is allergic to: _____

Has patient ever been hospitalized? For what reason? _____

Has patient ever had any of the following medical problems?

Adverse reaction to any medications	Yes [ ] No [ ]	Epilepsy/Seizures	Yes [ ] No [ ]
AIDS/HIV+	Yes [ ] No [ ]	Frequent headaches	Yes [ ] No [ ]
Allergies	Yes [ ] No [ ]	Frequent sore throats	Yes [ ] No [ ]
If yes, please list_____		Heart disease	Yes [ ] No [ ]
Artificial joints	Yes [ ] No [ ]	Heart murmur	Yes [ ] No [ ]
Artificial valves	Yes [ ] No [ ]	Hepatitis	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Herpes	Yes [ ] No [ ]
Asthma/Hay fever	Yes [ ] No [ ]	High/low blood pressure	Yes [ ] No [ ]
Bleeding problems	Yes [ ] No [ ]	Kidney problems	Yes [ ] No [ ]
Blood Transfusion	Yes [ ] No [ ]	Mitral valve prolapse	Yes [ ] No [ ]
Cancer	Yes [ ] No [ ]	Psychiatric problems	Yes [ ] No [ ]
Chemotherapy/Radiation	Yes [ ] No [ ]	Rheumatic fever	Yes [ ] No [ ]
Congenital heart defects	Yes [ ]No [ ]	Sinus problems	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Tonsils or adenoids removed	Yes [ ] No [ ]
Dizziness/Fainting	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Emphysema/Difficulty breathing	Yes [ ] No [ ]		

Female patients:
Have you started your menstrual cycle? Yes [ ] No [ ] Date of first menstruation_____
(This question helps Dr. Wittler determine the amount of growth remaining.)
Are you currently taking birth control pills? Yes [ ] No [ ]
(Some antibiotics block the effectiveness of these medications.)
Are you currently pregnant? Yes [ ] No [ ]
(Dr. Wittler doesn't take X-rays on patients who are or may be pregnant.)

Dental History

Dentist's name_____ Date of last visit_____

What are the main concerns that orthodontic treatment should accomplish? _____

Is this your first orthodontic exam?	Yes [ ] No [ ]	Has patient ever had any of the following habits?	
Does patient like his/her smile?	Yes [ ] No [ ]	(If habit stopped, please indicate when)	
Has there ever been injury to the face		Clenching or grinding teeth.	Yes [ ] No [ ]
mouth, teeth, or chin?	Yes [ ] No [ ]	Lip sucking or biting	Yes [ ] No [ ]
Has there ever been pain, tenderness,		Mouth breathing	Yes [ ] No [ ]
clicking, or popping in the jaw joint?	Yes [ ] No [ ]	Nail biting	Yes [ ] No [ ]
Has there ever been difficulty in chewing?	Yes [ ] No [ ]	Speech problems	Yes [ ] No [ ]
Do patient's gums ever bleed?	Yes [ ] No [ ]	Tongue thrust	Yes [ ] No [ ]
Has patient ever been diagnosed with		Thumb or finger sucking	Yes [ ] No [ ]
periodontal disease ?	Yes [ ] N0 [ ]		

I understand that this information is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

Signature: Date: