

SHULTS ORTHODONTICS, PLLC

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MEDICAL HISTORY

Patient's Name: _____

General Health: _____ Good _____ Fair _____ Poor

Physician's Name: _____

Today's Date: _____ - _____ - _____

Height: _____ Weight: _____

Telephone: _____ - _____ - _____

YES No

_____ _____ Is Patient currently under a physician's care

_____ _____ Does Patient have regular medical exams

_____ _____ Is Patient presently taking any medications

If so, please list: _____

_____ _____ Has a physician instructed Patient to take antibiotics before dental treatment

Does Patient have allergies to:

_____ _____ Medicines/Antibiotics - If so, please list: _____

_____ _____ Pollen, Dust, Food, Other: _____

PLEASE CIRCLE ANY THAT PERTAIN TO PATIENT'S HEALTH

Anemia	Diabetes	Heart Condition	Pneumonia
Arthritis	Dizziness	Hepatitis	Pregnant
Asthma	Earaches	Jaundice	Prolonged Bleeding
AIDS/HIV	Emotional Condition	Kidney Problem	Rheumatic Fever
Bleeding Disorder	Endocrine Problem	Liver Problem	Rheumatic Heart Disease
Blood Pressure Disorder	Epilepsy	Mental Disorder	Speech Disorder
Bone Disorder	Fainting Spells	Mitral Valve Prolapse	Tuberculosis
Broken Bones With Pins	Hay Fever	Neck Pain or Swelling	Venereal Disease
Cancer/Chemotherapy	Headaches	Nervous Disorder	Other: _____
Convulsions			

DENTAL HISTORY

Yes No

_____ _____ Has an orthodontist been consulted previously

_____ _____ Has Patient been informed of missing or extra teeth

_____ _____ Has Patient ever had injuries to face, mouth, or teeth _____

_____ _____ Does Patient have pain when chewing, yawning, or opening wide

_____ _____ Does Patient's jaw joint click or pop

_____ _____ Is pain associated with the jaw joint

_____ _____ Does Patient's jaw "lock" open or closed

_____ _____ Does Patient have tenderness or soreness in the jaw joints

_____ _____ Does Patient have any pain in the face, neck or mouth

_____ _____ Does Patient have any problem chewing or swallowing

_____ _____ Do Patient's teeth stick out

_____ _____ Has Patient ever been a finger or thumb sucker

_____ _____ Has Patient ever had previous orthodontic care

If so please describe: _____

_____ _____ Has anyone else in Patient's family had orthodontic treatment

If so please describe: _____

_____ _____ Does Patient get cold sores or fever blisters

_____ _____ Does Patient have sores of any kind in mouth today