

## 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 or latex? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any major operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

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

Abnormal bleeding/Hemophilia    Diabetes    Pneumonia    Herpes  
Hepatitis/Liver problems    Anemia    Dizziness    Bone Disorders  
Radiation/Chemotherapy    Arthritis    Epilepsy    High Blood Pressure  
Asthma or Hayfever    HIV / Aids    Tumor or Cancer    Rheumatic Fever  
Gastrointestinal Disorders    Kidney problems    Tuberculosis    Heart Murmur  
Congenital Heart Defect    Nervous Disorders    Heart Problems    Prolonged Bleeding  
Are there any medical conditions we have not discussed that you feel we should be aware of?

## DENTAL HISTORY

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 or pressure? \_\_\_\_\_  
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 Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?  
Yes No Has anyone in your family received orthodontic treatment? (Who) \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_  
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? \_\_\_\_\_

**Female Patients only:**

Yes No Are you pregnant?  
Yes No Has menstruation started?

*\*By signing, I agree that the information is true to the best of my knowledge. I have received the Privacy Policies of Neale Orthodontics. I hereby authorize OrthoBanc, LLC, on behalf of Dr. William D. Neale to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. I consent to the taking of photographs and x-rays before, after and during treatment and to the use of same by the doctor in scientific papers or demonstrations.*

Signature of Parent / Guardian: \_\_\_\_\_