



Please indicate yes or no for any condition you have experienced:

Heart murmur .....	Yes	No	Sinus trouble .....	Yes	No
Rheumatic fever .....	Yes	No	Epilepsy .....	Yes	No
High blood pressure.....	Yes	No	Fainting .....	Yes	No
Low blood pressure.....	Yes	No	Arthritis .....	Yes	No
Hepatitis.....	Yes	No	Anemia / blood disease.....	Yes	No
Diabetes.....	Yes	No	Tumors / growths.....	Yes	No
Kidney disease .....	Yes	No	Thyroid / parathyroid problems.....	Yes	No
Asthma.....	Yes	No	Bone disorders.....	Yes	No
Tuberculosis .....	Yes	No	Seizures.....	Yes	No
Pneumonia.....	Yes	No	Endocrine problems.....	Yes	No
Often fatigued / exhausted .....	Yes	No	Frequent headaches.....	Yes	No
Nervous / anxious.....	Yes	No	Immune system problems.....	Yes	No
Any recent weight gain / loss .....	Yes	No	Psychiatric care.....	Yes	No
Cancer treatment.....	Yes	No	Prolonged bleeding.....	Yes	No

**Are you allergic or have reacted adversely to:**

Local anesthetics.....	Yes	No
Penicillin / other.....	Yes	No
Sulfa drugs?.....	Yes	No
Barbiturates, sedatives or sleeping pills.....	Yes	No
Aspirin.....	Yes	No
Iodine.....	Yes	No
Codeine or other narcotics.....	Yes	No
Other.....		

**DENTAL HISTORY**

Date of your last dental examination or treatment.....		
Have you had any serious problems associated with previous dental treatment? .....	Yes	No
Has there been any injuries to your face, mouth or teeth? .....	Yes	No
Has there been any treatment for problems of your jaw joint or for facial muscle spasms? .....	Yes	No
Have you ever sucked a thumb or fingers? .....	Yes	No
Until what age?.....		
Do you have any speech problems? .....	Yes	No
Are you a mouth breather? .....	Yes	No
At what times?.....		
Have you been informed of any missing or extra teeth? .....	Yes	No
Does food catch or collect between teeth? .....	Yes	No
Do you clench or grind your teeth? .....	Yes	No
Is there clicking, popping or grating noise from your jaw when chewing? .....	Yes	No
Is there numbness or tingling associated with your mouth or face? .....	Yes	No
Have you ever had orthodontic treatment or been treated for a bad bite? .....	Yes	No
Has an orthodontist been consulted previously? .....	Yes	No
Have you ever had periodontal (gum) disease? .....	Yes	No
Has either parent had orthodontic treatment? .....	Yes	No
Do you use mouthguard or plastic splint? .....	Yes	No
List any musical instruments played:.....		

**Signature**.....