



**CHRISTIAN P. MANLEY**  
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ORTHODONTICS

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## DENTAL HEALTH HISTORY

**Patient Name:** \_\_\_\_\_

**Check if you have had problems with any of the following:**

- |  |   |
|--|---|
| <input type="checkbox"/> Any injuries to face, mouth, teeth? | <input type="checkbox"/> Thumb, finger, lip sucking?        |
| <input type="checkbox"/> More than average amount of decay?  | <input type="checkbox"/> Any missing permanent teeth?       |
| <input type="checkbox"/> Any extra permanent teeth?          | <input type="checkbox"/> Any teeth removed by extraction?   |
| <input type="checkbox"/> Any difficulty swallowing/chewing?  | <input type="checkbox"/> Any pain or clicking when opening? |
- Is patient adopted? Y ( ) N ( ) What age? \_\_\_\_\_

Do you visit the dentist regularly? \_\_\_\_\_ Date of last visit? \_\_\_\_\_ Has an orthodontist been consulted previously? \_\_\_\_\_ Reason \_\_\_\_\_

Do you or have you taken any of the following medications:  Actonel  Boniva  Fosamax  Skelid  Didronel

What would you like orthodontic treatment to accomplish? \_\_\_\_\_

Patient's attitude toward orthodontic treatment?  Very motivated  Will cooperate if needed  Not motivated

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever taken any of the group of drugs referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine.)  Yes  No

Have you ever had a blood transfusion?  Yes  No If yes, give approximate Dates \_\_\_\_\_

List any serious illnesses \_\_\_\_\_ Is patient presently under physicians care for illness  Yes  No  
If yes, Reason \_\_\_\_\_

(Women) Are you pregnant?  Yes  No

Adolescent Females: Has menstruation begun  Yes  No If yes, Date: Month \_\_\_\_\_ Year \_\_\_\_\_ Approximately how much has patient grown in last year? \_\_\_\_\_

**Check if you have or have had any of the following:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Scarlet fever              |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Fainting       | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Hepatitis      | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Hemophilia     | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cough, Persistent       | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Rheumatic Fever       |   |

**MEDICATIONS**

List medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Y N  
( ) ( ) Latex  
( ) ( ) Local Anesthetic  
( ) ( ) Other - If yes please list \_\_\_\_\_

**SIGNATURE**

The above information is accurate and complete to the best of my knowledge. I will not hold my orthodontist or any member of his/her team responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record of medical/dental status I will also inform the practice.

Signature \_\_\_\_\_ Date \_\_\_\_\_