Christopher M. Rose, D.D.S., M.S.

Orthodontics for Children, Teens, & Adults

HEALTH HISTORY

Name _____ Birthdate _____ Age _____

Correct answers to the following questions will allow us to treat you on a more individual basis, providing appropriate care for your particular needs.

How do you feel:

About your teeth? _____ About preventive dentistry? _____

About receiving orthodontic treatment? _____

About coming to our office? _____

How would you describe your general health? _____

Have you ever had any serious trouble associated with previous dental treatment? _____

What is the date of your last dental exam? _____ Last cleaning? _____

Has your dentist corrected your bite by grinding your teeth? _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

Whom may we thank for referring you to our office? _____

General Dentist: _____ Phone: _____

Physician: _____ Phone: _____

Do you have, or have you ever had any of the following?

MOUTH:	YES	NO
Bleeding, sore gums……	[ ]	[ ]
Unpleasant taste / bad breath……	[ ]	[ ]
Burning tongue / lips……	[ ]	[ ]
Frequent blisters on lips / mouth……	[ ]	[ ]
Swelling / lumps in mouth……	[ ]	[ ]
Biting cheeks / lips……	[ ]	[ ]
Clicking / popping jaw……	[ ]	[ ]
Difficulty opening or closing jaw……	[ ]	[ ]
TEETH:		
Loose teeth……	[ ]	[ ]
Sensitive to hot……	[ ]	[ ]
Sensitive to cold……	[ ]	[ ]
Sensitive to sweets……	[ ]	[ ]
Sensitive to biting pressure……	[ ]	[ ]
Food getting caught between teeth……	[ ]	[ ]
Shifting position of teeth……	[ ]	[ ]
Change in bite……	[ ]	[ ]
ORAL HYGIENE: Do you use the following?		
Brush……	[ ]	[ ]
Dental floss……	[ ]	[ ]
Fluoride rinse……	[ ]	[ ]

Other _____

How often do you brush? _____

Toothbrush is: Soft [ ] Medium [ ] Hard [ ]

Are you **ALLERGIC** to or have you ever had a reaction to the following?

	YES	NO		YES	NO
Local anesthetics	[ ]	[ ]	Aspirin or Codeine	[ ]	[ ]
Penicillin / Antibiotics	[ ]	[ ]	Sedatives, Barbiturates	[ ]	[ ]
			Other _____		

Are you taking any of the following?

Antibiotic / sulfa drugs	[ ]	[ ]	Blood thinners	[ ]	[ ]
Blood pressure medication	[ ]	[ ]	Thyroid medication	[ ]	[ ]
Cortisone / steroids	[ ]	[ ]	Tranquilizers	[ ]	[ ]
Insulin / diabetes drugs	[ ]	[ ]	Nitroglycerin	[ ]	[ ]
Digitalis / heart medication	[ ]	[ ]	Antihistamines / allergy medication	[ ]	[ ]
Aspirin	[ ]	[ ]	Hormones		
Other medications _____			(including Birth Control Pills)	[ ]	[ ]

Please list any medications currently being taken (Name and Dosage)

1. _____ 3. _____
2. _____ 4. _____

Do you now have, or have you ever had any of the following?

	YES	NO		YES	NO
NERVOUS SYSTEM			Heart surgery	[ ]	[ ]
Stroke	[ ]	[ ]	Anemia	[ ]	[ ]
Headaches (migraines)	[ ]	[ ]	Blood transfusion	[ ]	[ ]
Convulsions / Epilepsy	[ ]	[ ]	Other _____		
Numbness / tingling	[ ]	[ ]	BONE / MUSCLES		
Dizziness / fainting	[ ]	[ ]	Arthritis / Rheumatism	[ ]	[ ]
Psychiatric treatment	[ ]	[ ]	Artificial joints	[ ]	[ ]
RESPIRATORY SYSTEM			DIGESTIVE SYSTEM		
Tuberculosis	[ ]	[ ]	Hepatitis (A or B) / Jaundice	[ ]	[ ]
Emphysema	[ ]	[ ]	Liver disorders	[ ]	[ ]
Asthma / hay fever	[ ]	[ ]	Ulcers	[ ]	[ ]
Persistent cough	[ ]	[ ]	URINARY SYSTEM		
Difficulty breathing			Kidney disease	[ ]	[ ]
(when lying down)	[ ]	[ ]	Burning on urination	[ ]	[ ]
ENDOCRINE SYSTEM			Venereal disease	[ ]	[ ]
Diabetes [ ]	[ ]		OTHER		
Family history of diabetes	[ ]	[ ]	Sinus problems	[ ]	[ ]
Thyroid condition	[ ]	[ ]	Radiation therapy	[ ]	[ ]
Other _____			Tumors or growths	[ ]	[ ]
HEART / CIRCULATORY SYSTEM			Cancer	[ ]	[ ]
Rheumatic / scarlet fever	[ ]	[ ]	AIDS (Acquired Immuno-		
Heart murmur	[ ]	[ ]	Deficiency Syndrome)	[ ]	[ ]
Chest pain / discomfort	[ ]	[ ]	Pregnant	[ ]	[ ]
Heart attack / trouble	[ ]	[ ]	Tonsillectomy / Adenoidectomy	[ ]	[ ]
Shortness of breath	[ ]	[ ]	Surgery (any operations)	[ ]	[ ]
Swelling of ankles [ ]	[ ]		List _____		
High or low blood pressure [ ]	[ ]		Serious injury / hospitalization [ ]	[ ]	
Congenital heart disease	[ ]	[ ]	List _____		
Artificial heart valve	[ ]	[ ]	_____		

Are you currently under the continuing care of a physician or other health care practitioner? [ ] [ ]

If so, please explain _____

To the best of my knowledge, all of the preceding answers are true and correct. If any changes in my health or medication occur, I will inform the office of Dr. Christopher M. Rose immediately.

_____ _____

Patient / Parent, Legal Guardian or Custodian (if patient is a minor) Date