Ising Orthodontics Medical History Form

Date_____ How did you hear about our office? _____

Patient's Name _____Patient's Dentist _____ Date of last Cleaning_____

Patient's Physician _____

Dental History **Medical History**

Prior orthodontic treatment?	Y	N	Any allergies to drugs, foods, or environment?	Y	N
If yes, when and where?	Y	N	Any birth defects?	Y	N
Any Periodontal (gum) problems?	Y	N	Any learning disabilities or ADD/ ADHD?	Y	N
Any permanent teeth removed?	Y	N	Thyroid disease?	Y	N
Any problems with your jaw joints?	Y	N	Bleeding disorder or Hemophilia?	Y	N
Thumb sucking or finger sucking?	Y	N	Diabetes?	Y	N
Any injuries to teeth or facial bones?	Y	N	Asthma?	Y	N
Mouth breathing, Snoring?	Y	N	Arthritis?	Y	N
Tongue thrusting?	Y	N	Heart Murmur or Mitral Valve Prolapse?	Y	N
Sleep apnea/CPAP use?	Y	N	Bisphosphonate use/Osteoporosis?	Y	N

If you answered yes to any of the questions please explain: _____
_____
_____
_____
_____
_____
_____
_____
_____

Artificial heart valve?	Y	N
Liver or Kidney disease?	Y	N
Cancer?	Y	N
Growth disorder?	Y	N
Seizures?	Y	N
Tonsils or Adenoids problem?	Y	N
Latex Allergy?	Y	N
Prescription Medications?	Y	N
Nicotine usage?	Y	N
TB, HIV, Hepatitis, other infectious disease?	Y	N
Any other issues not listed?	Y	N

I have read and understand the above questions. I will not hold Dr. Ising or any member of his team responsible for any errors or omissions that I have made in the completion of this form; if there are any changes to this history record or dental/medical status I will inform this practice.

_____
Signature Date

OFFICE USE ONLY:

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

_____
Signature (responsible party) Date

I have reviewed the above information and there are no changes; if there are changes I will inform this practice.

_____
Signature (responsible party) Date