	MEDICAL AND DENTAL HISTORY	Yes	No
1	Has patient every sustained injury to the head face or jaws?	☐	☐
2	Has patient ever been in an auto accident or had a severe fall?	☐	☐
3	Has patient ever been hospitalized? If yes, for what?	☐	☐
4	**IS PATIENT IN GOOD HEALTH?**	☐	☐
5	Does patient have history of major illness?	☐	☐
6	Has patient ever been under physicians care?	☐	☐
7	Has patient ever tested positive for hepatitis?	☐	☐
8	Has patient tested positive for the HIV virus?	☐	☐
9	Does patient have frequent headaches?	☐	☐
10	Does patient have pain in face , head, jaw, ears, or neck?	☐	☐
11	Does patient have jaw problems?	☐	☐
12	Does patient experience pain in his/her jaw while chewing?	☐	☐
13	Does patient notice noises in right or left jaw joints, (in front of ears) clicking, popping, grating or grinding when mouth is open or when chewing?	☐	☐
14	Has patients jaw ever stuck open or closed?	☐	☐
15	Does patients bite feel uncomfortable?	☐	☐
16	Does patient clench teeth during the day, or grind teeth at night?	☐	☐
17	Does patient wake up with sore teeth or jaw?	☐	☐
18	Does patient often have colds?	☐	☐
19	Does patient often have sore throats?	☐	☐
20	Does patient have tendency to ear infections?	☐	☐
21	Have tonsils / adenoids been removed? If yes, at what age?	☐	☐
22	Does patient have allergies / drug sensitivity? If yes, to what?	☐	☐
23	Is medication currently being taken? If yes, list all medications and reason for use.	☐	☐
24	Has patient sustained injuries to the face, mouth, or teeth?	☐	☐
25	Has patient every sucked thumb or fingers? If yes, till what age?	☐	☐
26	Does patient have any speech problems?	☐	☐
27	Is patient a mouth breather while awake?	☐	☐
28	Is patient a mouth breather while asleep?	☐	☐
29	Does patient have any missing or extra permanent teeth?	☐	☐
30	Has a previous orthodontist been consulted within the past 12 months?	☐	☐

Check if patient has been treated for:

☐ Liver Problems	☐ Asthma	☐ Endocrine Problems	☐ Jaw Joint Disorder (TMJ)
☐ Tuberculosis	☐ Heart Trouble	☐ Pneumonia	☐ Any Muscle-Joint Problems
☐ Epilepsy	☐ Prolonged Bleeding	☐ Bone Disorder	
☐ Nervous Disorders	☐ Anemia	☐ Kidney Problems	
☐ Fainting / Dizziness	☐ Rheumatic Fever	☐ Diabetes	

Other:

1. Is your child allergic to latex exam gloves?
2. Does your child have any mouth sores now?
3. Is your child very anxious or afraid of being examined?
4. Do you realize that this exam is painless?
5. The goals of the exam are to let you know the following:
   a. How serious your child's problem is.
   b. What kind of braces might be used.
   c. Whether teeth need not or should be removed.
   d. How many months of treatment is needed.
   e. The fee for orthodontic treatment.

Dr. Ted will provide you with a written summary of the consultation-examination.

____

RESPONSIBLE PARTY SIGNATURE

Don't forget to sign your name