SUTER ORTHODONTICS
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PATIENT HEALTH HISTORY

Date:_____

Patient Name: _____ **DOB:**_____

What is the reason for the orthodontic visit today? _____
Is the patient/self currently in pain? _____
How would you rate the patient/self's current dental health: GOOD FAIR POOR

Have you/patient ever had a serious/difficult problem associated with previous dental work? _____
If yes, briefly describe:_____

Has the patient/self ever had any pain or tenderness in the jaw joint (TMJ/TMD)? _____

Do you/patient like your smile? Y_____ N_____
Do your/patient's gums ever bleed? Y _____ N _____
How many times per week do you/patient floss? _____ How many times a day do you/patient brush?_____
Type of bristles on the toothbrush? HARD MEDIUM SOFT

Patient/Self's Primary Physician: _____ Phone#:_____
Last visit?_____
Would you rate your/patient's current physical health as: GOOD FAIR POOR
Are you/patient currently under the ongoing care of a doctor for a chronic health condition? _____
If yes, briefly describe: _____
Prescriptions/OTC Medications you/patient are currently taking (including dosage):_____
_____
_____

Are you/patient allergic to any of the following (please circle if so):

Aspirin Codeine Latex Penicillin Erythromycin Dental Anesthetics Tetracycline

Any other allergies we need to know about? _____

Have you/patient ever had any of the following medical problems (circle any that apply):

Heart Murmur
Cancer
Diabetes
Rheumatic Fever
HIV/AIDS
Hemophilia
Asthma
Hepatitis
Tuberculosis
Prosthesis
Autism
Radiation Treatment
Congental Heart Defect
Convulsions/Epilepsy
Hearing Impairment
Kidney/Liver Problems
Shingles
Ulcers/Colitis
Sinus Problems
Artificial Valves
Mitral Valve Prolapse
Severe/Frequent Headaches
Drug/Alcohol Abuse
Difficulty Breathing
Heart Attack
Abnormal Bleeding
Vision Impairment
History of Scarlet Fever
Fever Blisters
Emphysema
Glaucoma
Pacemaker
Artificial Bones/Joints
High/Low Blood Pressure
Anemia
Blood Transfusions

Any other physical or psychological issues you feel we should know about in order to give you the best care possible? _____
_____
_____

For Women:
Are you currently pregnant or nursing? _____

For Children:
Does the child currently/previously have any of the following habits? (please circle if so)

Thumb/Finger sucking Lip sucking/biting Nail Biting Nursing Bottle habits

I understand that the information I have given is true and correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes to my/my child's medical status. I authorize the dental staff to perform any necessary dental services to myself/my child that may be needed.

Responsible party's printed name: _____ Relationship to patient:_____

Responsible Party's signature: _____

----------OFFICE USE ONLY----------

I verbally reviewed the medical/dental information above with the patient/parent/guardian and patient name herein.
Initials:_____ Date:_____ Dr's Notes:_____

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