SCOTIA ORTHODONTICS

SMILE WITH CONFIDENCE

MEDICAL HISTORY

Patient Name: _____ Is the patient in good health? Circle One YES NO

Is patient taking prescriptions or over the counter medications? YES NO Please list all prescriptions and medications: _____

If female, is the patient pregnant or possibly pregnant? YES NO

Under the care of a physician? YES NO Explain:_____

Physician name and phone number:_____

History of major illness? YES NO Describe:_____

Any sensitivities or allergies? YES NO List:_____

Have tonsils and/or adenoids been removed? YES NO When?_____

Any condition not listed that you would like the doctor to know about?_____

Has the patient had any of the following medical conditions? Please circle YES of NO

YES NO **ADD/ADHD**	YES NO **CANCER**	YES NO **HERPES**	YES NO **OSTEOPOROSIS/ OSTEOPENIA**
YES NO **AUTISM SPECTRUM**	YES NO **COLD SORES**	YES NO **HEART MURMUR**	YES NO **PNUEMONIA**
YES NO **AIDS/ARC**	YES NO **DIABETES**	YES NO **HEART CONDITION**	YES NO **PSYCHIATRIC PROBLEM**
YES NO **ANEMIA**	YES NO **DIZZY SPELLS**	YES NO **KIDNEY PROBLEM**	YES NO **RADIATION TREATMENT**
YES NO **ANGINA**	YES NO **EPILEPSY**	YES NO **LIVER PROBLEM**	YES NO **RHEUMATIC FEVER**
YES NO **ARTHRITIS**	YES NO **FAINTING**	YES NO **HIGH BLOOD PRESSURE**	YES NO **TUBERCULOSIS**
YES NO **ASTHMA**	YES NO **FEVER BLISTERS**	YES NO **LOW BLOOD PRESSURE**	YES NO **ULCERS/COLITIS**
YES NO **BLOOD DISORDER**	YES NO **GI DISORDERS**	YES NO **LYME DISEASE**	YES NO **SNORING**
YES NO **BONE DISORDER**	YES NO **HEADACHES**	YES NO **NERVOUS DISORDER**	YES NO **OBSTRUCTIVE SLEEP APNEA**

DENTAL HISTORY

Main orthodontic concern_____

Injuries to the face, mouth, or chin? YES NO Explain:_____

Pain/tenderness/locking of the jaw joint? YES NO Explain:_____

Concerning the following habits please circle YES or NO:

YES NO **Chewing/Eating problem**	YES NO **Nail biting**	YES NO **Clenching and/or grinding**
YES NO **Lip biting**	YES NO **Pen/Pencil biting**	YES NO **Tongue Thrusting**
YES NO **Mouth breathing**	YES NO **Speech Problems**	YES NO **Thumb/Finger sucking**

SIGNATURE

I believe the information I have provided is correct to the best of my knowledge, that it will held in strict confidence and it is my responsibility to inform this office of any changes in my or my child's medical status.

I hereby authorize release of information related to insurance claims. I consent to examination by the doctor and I authorize payment of insurance benefits.

Signature_____ Date_____

Patient/Parent/Guardian yearly review

12 month_____ Initial and date

24 month_____ Initial and date

36 month_____ Initial and date