novus Orthodontics
The Next Generation In Orthodontics

MEDICAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

( ) JOINT SWELLING
( ) BONE DISORDERS
( ) HEART TROUBLE
( ) MITRAL VALVE TROUBLE
( ) RHEUMATIC TROUBLE
( ) DIABETES
( ) EMOTIONAL PROBLEMS
( ) BRAIN INJURY
( ) KIDNEY/LIVER INVOLVEMENT
( ) JOINT PROSTHESIS
( ) LATEX ALLERGY
( ) TUBERCULOUS
( ) ANEMIA
( ) EPLIEPSY (CONVULSIONS)
( ) PROLONGED BLEEDING
( ) FAINTNESS DIZZINESS
( ) TONSILS REMOVED
( ) ADENOIDS REMOVED
( ) SORE THROAT
( ) TONSILILITIS
( ) EARACHES
( ) METAL/PLASTIC ALLERGY

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:
(Y) (N) RHUEMATOID ARTHRITIS
(Y) (N) LUPUS

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:
____
____
____

DENTAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

( ) ANY INJURIES TO FACE, MOUTH, OR TEETH
( ) THUMB, FINGER SUCKING
( ) MORE THAN AVERAGE AMOUNT OF TOOTH DECAY
( ) EXTRA PERMANENT TEETH
( ) TEETH REMOVED BY EXTRACTION
( ) DIFFICULTY IN SWALLOWING OR CHEWING
( ) ANY PAIN OR CLICKING WHEN OPENING MOUTH
( ) IS PATIENT ADOPTED? AT WHAT AGE? ________
( ) PREVIOUSLY CONSULTED BY ANOTHER ORTHODONTIST

(Y) (N) DOES THE PATIENT VISIT THE DENTIST REGULARLY?
DATE OF LAST VISIT_____________________

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION:
____
____
____

IS PATIENT PRESENTLY UNDER PHYSICIAN CARE FOR ANY REASON?

____

NAME OF PRIMARY PHYSICIAN: ___________________________________

LIST ANY OTHER SERIOUS ILLNESSES:

____

LIST DRUGS OR MEDICATIONS BEING TAKEN:
____
____

DO YOU TAK ANY MEDICATIONS FOR OESTEOPOROSIS?

IF YES, PLEASE LIST: ____

LIST ANY ALLERGIES: ____

Signature: ____Date:_____________________________________

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