

KITA ORTHODONTICS

Health History Form

REVISED 5/15/2008

Please fill out the following information as it pertains to you. This information is confidential and necessary to provide you with the best possible care. If you do not understand a question, then please ask a staff member for assistance.

Patient Name: _____

Health History:

- 1) Are you currently under the care of a physician? _____ For what reason? _____

- 2) Are you currently taking any medications? _____ If yes, please list them with dosage. _____

- 3) Are you allergic to anything? (Drugs, foods, latex, etc.) _____ List: _____
- 4) Do you smoke or use any other tobacco products? _____
- 5) Have you ever been seriously ill? _____ Please explain: _____
- 6) Have you ever taken cortisone, steroids, or similar drugs? _____ When: _____
- 7) Have you ever bled excessively from minor cuts, previous surgery or following tooth extraction? _____
- 8) Have you ever been diagnosed with anemia? _____ When? _____
- 9) Does anyone in your family have a history of: Bleeding problems _____ Who? _____
Diabetes _____ Who? _____
Heart Disease _____ Who? _____
- 10) Do you have any heart conditions (e.g. heart murmur, prosthetic valves, etc.)? _____
- 11) Have you ever had rheumatic fever? _____
- 12) Do you have any joint prostheses? _____ Where? _____
- 13) Have you ever had tuberculosis? _____
- 14) Have you ever had any liver or kidney problems? _____ Explain? _____
- 15) Have you ever had thyroid problems? _____ Are you medicated for this problem? _____
- 16) Are you susceptible to epileptic seizures? _____ What medication do you take? _____
- 17) Have you had your tonsils removed? _____ When? _____ Adenoids removed? _____ When? _____
- 18) Have you ever been tested for AIDS? _____ Results: _____
- 19) Women --- Are you pregnant? _____
- 20) Have you ever had any trauma to your head or face? _____ If yes, please explain. _____

- 21) Have any teeth been damaged due to trauma? _____ Which ones? _____
- 22) Has the patient ever sucked their thumb, finger or lip? _____ until what age? _____
- 23) Does the patient breathe predominantly through the mouth? _____
- 24) Does the patient have any speech difficulty? _____
- 25) Does the patient have any noticeable difficulty in chewing and swallowing food? _____
- 26) Does the patient clench or grind their teeth during the day or night? _____
- 27) Does the patient experience any clicking, popping, or pain upon opening or closing of their mouth?

More questions are on the back

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- 28) Does the patient notice bleeding of the gums while brushing? _____
- 29) Does the patient visit the dentist regularly? _____ Date of last visit: _____
- 30) Have you been informed of any missing permanent teeth? _____
- 31) Have you been informed of any extra permanent teeth? _____
- 32) Does anyone in the family have a similar dental problem? _____
- 33) Has any member of the family had any orthodontic treatment before? _____ Who? _____
- 34) Does the **patient** want his or her teeth straightened? _____
- 35) Are you aware of any gagging type reflex? _____
- 36) Do you need to be premedicated with antibiotics before you see your dentist? _____
If yes, with what? _____

For Growing Patients Only

- 37) **Male.** Has the patient started to shave? _____
Seen his voice change? _____
Has there been any other signs of pubertal development? (i.e. axillary hair, etc.) _____
- 38) **Female.** Has the patient started her monthly period? _____ Age? _____
Has there been any signs of pubertal development? (i.e. axillary hair, etc.) _____

What is the reason for visiting our office today?

We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should pay for the services and seek reimbursement from the other parent. To the best of my knowledge, the above information and the information on the form named 'Kita Orthodontics Patient and Parent Information' are complete and correct. I understand that incomplete or inaccurate information could be hazardous to my health and/or the health of the doctor and his staff. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

Date

Signature of Patient

Signature of Parent or Guardian

Date reviewed

Signature of doctor

For Office Use Only

Date: _____ Health History Update: _____

Signature of doctor

Signature of patient/parent

Date: _____ Health History Update: _____

Signature of doctor

Signature of patient/parent