Encino Orthodontics

Fouy Chau, D.D.S.,M.S.

Medical/Dental History Form

Dentist Name _____ Phone # _____

Address _____
Street City State Zip

Date of Last Check-up? _____

Have tonsils and/or adenoids been removed? Yes ❑ No ❑ If yes, when? _____

Have any teeth been removed by your dentist? Yes ❑ No ❑

Any thumb or finger sucking habits? Yes ❑ No ❑ If yes, until what age? _____

Any other habits? (Nail biting, pen chewing, grinding teeth at night etc.) Yes ❑ No ❑ If yes, what habit? _____

Any complaints of "clicking" or jaw pain when opening or closing? Yes ❑ No ❑ If yes, please explain: _____

Has there been any speech therapy? Yes ❑ No ❑

Has there been any trauma to teeth or chin? Yes ❑ No ❑

Have you seen an orthodontist in the past? Yes ❑ No ❑ If yes, when? _____

Physician's Name _____ Phone # _____

Please complete the following medical history by checking the applicable answer.

If any explanation is required, please use the space below.

	Yes	No		Yes	No		Yes	No
1. Heart Disease	❑	❑	11. Psychiatric Treatment	❑	❑	21. Allergies	❑	❑
2. High Blood Pressure	❑	❑	12. Arthritis	❑	❑	Penicillin	❑	❑
3. Blood Disorder – Anemia	❑	❑	13. Tumor History	❑	❑	Other Antibiotics	❑	❑
4. Rheumatic Fever	❑	❑	14. Venereal Disease	❑	❑	Codeine, Aspirin	❑	❑
5. Heart Murmur	❑	❑	15. Sinus Trouble	❑	❑	Local Anesthetic, Novocain	❑	❑
6. Thyroid Disease	❑	❑	16. Ulcers	❑	❑	Others	❑	❑
7. Diabetes	❑	❑	17. Radiation Treatment	❑	❑	22. Asthma	❑	❑
8. Stroke	❑	❑	18. Liver or Kidney Disease	❑	❑	23. Tuberculosis, Emphysema	❑	❑
9. Epilepsy	❑	❑	19. Hepatitis, Jaundice	❑	❑	24. Do you smoke?	❑	❑
10. Fainting	❑	❑	20. AIDS/HIV+	❑	❑	25. Are you pregnant?	❑	❑

Is patient currently taking any medication, and if so what? _____

What concerns do you have regarding your teeth today? _____

_____

_____ _____

Signature of patient/(parent if minor) Date