



Patient's Name: _____ **Date** _____

What is the main purpose for your visit today?

- | | | |
|---|---|--|
| <input type="checkbox"/> Orthodontic Evaluation | <input type="checkbox"/> Transfer Treatment | <input type="checkbox"/> Obstructive Sleep Apnea |
| <input type="checkbox"/> Orthodontic Reevaluation | <input type="checkbox"/> Jaw Joint Problems | <input type="checkbox"/> Other |
| <input type="checkbox"/> Evaluation for Braces | <input type="checkbox"/> Snoring Treatment | |

What are your main concerns?

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Crooked Teeth | <input type="checkbox"/> Mis-Shaped teeth | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tooth Wear/Grinding |
| <input type="checkbox"/> Cross bite | <input type="checkbox"/> Gummy Smile | <input type="checkbox"/> Difficulty Chewing | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Crowding | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Thumb/Finger Habit | <input type="checkbox"/> Clenching |
| <input type="checkbox"/> Spacing | <input type="checkbox"/> Receding Gums | <input type="checkbox"/> Excessive Wear | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Overbite | <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Difficulty Opening | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Underbite | <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Wrong Jaw size | <input type="checkbox"/> TMJ Problems | <input type="checkbox"/> Difficulty Closing | |

Dental History (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> My dental health is good. | <input type="checkbox"/> Extra or Missing Teeth | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> My dental health is fair. | <input type="checkbox"/> Broken or Decayed Teeth | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> My dental health is poor. | <input type="checkbox"/> Impacted Teeth | <input type="checkbox"/> Finger Sucking |
| <input type="checkbox"/> I have had braces before. | <input type="checkbox"/> Permanent Tooth Removal | <input type="checkbox"/> Nail Biting |
| <input type="checkbox"/> My parent(s) have had braces. | <input type="checkbox"/> Speech Problem | <input type="checkbox"/> Other |
| <input type="checkbox"/> Mouth/Face/Jaw Injury | <input type="checkbox"/> I have previously been evaluated for braces | |

How frequently do you have dental check-ups? Twice a year Once a year Emergency Only Never

Have you had a dental check-up in the last 6 months? Yes No Cannot Recall

Brushing Frequency: Once a day Twice a day Three + times a day Rarely Brush After Meals

Flossing Frequency: Once a day Twice a day Three + times a day Occasionally After Meals Never

Do you use a supplemental rinse? w/Fluoride Anti-Plaque No

Have you ever used Bisphosphonates (osteoporosis)? Yes No

Medical History: I HAVE NONE OF THESE

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> CPAP Usage | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Liver problems | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Mononucleosis | |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Obstructive Sleep Apnea | |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnant (currently) | |

Allergies (Check all that apply):

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> I HAVE NO ALLERGIES | <input type="checkbox"/> Anesthetics (dental) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex |
| | <input type="checkbox"/> Metals | <input type="checkbox"/> Other |

Medications (Please List): Yes No

Airway History (Check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> I HAVE NONE OF THESE | <input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Tonsils Removed |
| <input type="checkbox"/> Abnormal Swallowing Pattern | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Adenoids Removed |
| <input type="checkbox"/> I do not get restful sleep | <input type="checkbox"/> I have had a sleep study | <input type="checkbox"/> I have a diagnosed sleep disorder |
| <input type="checkbox"/> I use a CPAP machine | <input type="checkbox"/> I use an oral sleep appliance | <input type="checkbox"/> I have been told I snore |
| <input type="checkbox"/> Other _____ | | |