Health History

Has the patient had any history of or difficulty with any of the following? If yes, please check the box.

- ☐ AIDS/H.I.V.
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Problems
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Venereal Disease

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Nickel
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other _____

Medications

List medications the patient is currently taking:

_____

_____

_____

Major Hospitalizations

Date (or age)	Reason
_____	_____
_____	_____
_____	_____

Other

Family Physician _____

Tonsils Present? ☐ Yes ☐ No

If no, age at removal _____

Adenoids Present? ☐ Yes ☐ No

If no, age at removal _____

Dental History

Oral Habits

- ☐ Finger/Thumb Sucking
- ☐ Lip/Tongue Biting
- ☐ Nail Biting
- ☐ Mouth Breathing
- ☐ Grinding Teeth
- ☐ Smoke/chew tobacco
- ☐ Other _____

TMJ History (Jaw Joints)

- ☐ Popping
- ☐ Clicking
- ☐ Pain
- ☐ Locking open
- ☐ Locking closed
- ☐ Previous treatment?
- ☐ Other _____

Additional Information

Any additional information for Dr. Curtis:

_____

_____

Signature

I affirm this information to be accurate, and will inform Dr. Curtis of any change in medications or health status at the beginning of each appointment.

_____ _____ / _____ / _____

Signature (parent's signature if patient is a minor) Date