West Seattle Orthodontics Heidi K. Horwitz, DDS

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your orthodontic care. All information will be kept strictly confidential.

Medical History

Physician's Name: Address: Phone:

Have you experienced any recent health problems? ☐ Yes ☐ No Explain: ______________________________

Any major change in your health recently? ☐ Yes ☐ No Explain: ______________________________

Are you currently under a physician's care? ☐ Yes ☐ No Explain: ______________________________

Are you currently taking medications? ☐ Yes ☐ No Explain: ______________________________

Have you received a blood transfusion? ☐ Yes ☐ No Reasons:______________________________

Have your tonsils or adenoids been removed? ☐ Yes ☐ No When:______________________________

Please check if you have had any of the following conditions:

Yes No		Yes No		Yes No		Yes No	
☐ ☐	Endocrine Disorders	☐ ☐	Mouth Breather	☐ ☐	Blood Disorders/Bleeding Problems	☐ ☐	Liver Disease
☐ ☐	Prolonged Bleeding	☐ ☐	AIDS or H.I.V. Positive	☐ ☐	Cancer	☐ ☐	Tonsillitis
☐ ☐	Heart Surgery date: _____	☐ ☐	Diabetes	☐ ☐	Bone Disorders	☐ ☐	Bronchitis
☐ ☐	Heart Murmur	☐ ☐	Hepatitis (type?________)	☐ ☐	Growth Disorders	☐ ☐	Headaches
☐ ☐	Rheumatic Fever	☐ ☐	Tuberculosis	☐ ☐	Anemia	☐ ☐	Anxious/ Nervous
☐ ☐	Kidney Trouble	☐ ☐	Herpes (oral-cold sores)	☐ ☐	Asthma	☐ ☐	Emotional Problems
☐ ☐	Developmental Disorder	☐ ☐	Fainting	☐ ☐	Epilepsy	☐ ☐	Hives/Rash

Is there any other condition you think we should know about?

Dental History

Dentist's Name: Address: Phone:

Dental Specialist's Name: Address: Phone:

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if problem exists Date of last exam:___________

Is there any unfinished care to be completed with your dentist? ☐ Yes ☐ No Explain: ____________________

Are you frightened about dental treatment? ☐ Yes ☐ No Explain: ____________________

Have you had an unpleasant experience in a dental office? ☐ Yes ☐ No Explain: ____________________

Do you play any musical instruments? ☐ Yes ☐ No Explain: ____________________

Have you consulted an orthodontist previously? ☐ Yes ☐ No Explain: ____________________

Have teeth (either primary or permanent) been moved? ☐ Yes ☐ No Explain: ____________________

Have you had any previous orthodontic treatment? ☐ Yes ☐ No Explain: ____________________

Are you satisfied with prior treatment? ☐ Yes ☐ No Explain: ____________________

Have you noticed any changes in your bite or dental alignment? ☐ Yes ☐ No Explain: ____________________

What are the chief concerns you have related to the position of your teeth or bite?

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate:

What concerns has your dentist expressed concerning your bite or dental alignment:

☐ Wear or fractures teeth ☐ Difficulty with cleaning related to alignment of teeth

☐ Bone/gum tissue loss ☐ Jaw joint or muscle tightness or discomfort

☐ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)

☐ Other:

Please check if there is a history of:

Yes No		Yes No		Yes No	
☐ ☐	Clenching teeth	☐ ☐	Grinding teeth	☐ ☐	Headaches
☐ ☐	Jaw joint popping	☐ ☐	Jaw clicking	☐ ☐	Jaw soreness
☐ ☐	Muscle Soreness around head and neck	☐ ☐	Ringing in the ears	☐ ☐	Speech Problems
☐ ☐	Mouth Breathing: Awake___ Asleep___				

Is there any other information that may be helpful?

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For office use only

Reviewed by:_______________________________