Medical History

Physician: _____ **Phone:** _____ **Date of last exam:** _____

Patient's height: _____ **Mother's Height:** _____ **Father's Height:** _____

Please indicate YES if you currently have or have ever had any of the following medical conditions

Heart Disease	Yes O No O	Mononucleosis	Yes O No O
Respiratory Disease	Yes O No O	Hepatitis	Yes O No O
Blood Disease	Yes O No O	Polio	Yes O No O
Liver Disease	Yes O No O	Diabetes	Yes O No O
Thyroid Disease	Yes O No O	Anemia	Yes O No O
Kidney Disease	Yes O No O	Hemophilia	Yes O No O
Venereal Disease	Yes O No O	Emphysema	Yes O No O
Intestinal Disease	Yes O No O	Epilepsy	Yes O No O
Bone Disease	Yes O No O	Nervous/Emotional Problems	Yes O No O
Endocrine Problems	Yes O No O	Problems with Wound Healing	Yes O No O
HIV Positive	Yes O No O	Rheumatic/Scarlet Fever	Yes O No O
Blood Transfusion	Yes O No O	Rheumatism or Arthritis	Yes O No O
Tumors or Cancer	Yes O No O	Is Patient Under Medical Care	Yes O No O
Asthma or Hay Fever	Yes O No O	History of Fainting or Dizziness	Yes O No O
Tuberculosis	Yes O No O	Does the Patient Have a Drug Addiction	Yes O No O
Broken Bones	Yes O No O		
Prolonged Bleeding	Yes O No O	Is the Patient Pregnant	Yes O No O
Yellow Jaundice	Yes O No O	Does the Patient Smoke	Yes O No O
Radiation Therapy	Yes O No O	Is the Patient in Good Health	Yes O No O
Chemical Therapy	Yes O No O	Has the Patient had Fever Blisters	Yes O No O

If female, has Menstruation begun Yes O No O If Yes, When: _____

Is the Patient allergic to anything Yes O No O

Please list all allergies: _____

Is the patient currently taking any medication Yes O No O

Please list all medications: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about? Yes O No O

If yes, please list: _____

It is our goal to give every patient a great, healthy smile. Please let us know of any delayed development, social disabilities, ADD, ADHD, Bipolar, Autism, etc., so we can help you or your child receive the best care possible: _____

Dental History

Dentist: _____ **Date of last exam/cleaning:** _____

Has the Patient Seen a Dentist in the Last Year	Yes O No O	_____
Any Pain, Clicking or Discomfort in or Near the Ears	Yes O No O	_____
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident	Yes O No O	_____
Have you Been Informed of Missing or Extra Permanent Teeth	Yes O No O	_____
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam	Yes O No O	_____
Have the Patient's Tonsils or Adenoids Been Removed	Yes O No O	_____
Do You Feel the Patient Can Benefit From Orthodontic Treatment	Yes O No O	_____
Does the Patient Want to Improve Their "Smile" and "Bite"	Yes O No O	_____
Would the Patient Mind Wearing Braces	Yes O No O	_____

Does the Patient Have or Ever Had Any of the Following Habits?

Cheek, Tongue, or Lip-Chewing	Yes O No O	Clenching Teeth	Yes O No O
Finger Nail Biting	Yes O No O	Tongue Thrusting	Yes O No O
Thumb Sucking	Yes O No O	Grinding Teeth	Yes O No O
Mouth Breathing	Yes O No O	Speech Problems	Yes O No O

Has the Patient Been Examined by an Orthodontist Before? If yes, when: _____

Have Other Members of the Family had Orthodontic Treatment? If Yes, Were you Happy With the Result? Yes O No O

If No, Why? _____

In Your Own Words, What is the Orthodontic Problem? _____

I understand the information given is correct and will be held in the strictest confidence, and that it is my responsibility to inform Noel Orthodontics of any changes in this patient's medical status.

_____ _____ _____ _____

Patient Signature **Date** **Parent Signature** **Dr. Lloyd G. Noel, DMD, MS, PC**

Updates (Date and Initial): _____

_____