



www.drbutterfoss.com

HEALTH HISTORY

Patient Name: _____

Date: _____

Is the patient currently under the care of a physician? Yes No

If YES, for what reason? _____

Physician _____

Phone # _____

History of major illness? Yes No If YES, Please describe _____

Any sensitivities or allergies? Yes No If YES, Please list _____

Currently taking any medications? Yes No If YES, Please list _____

Does the patient smoke or use smokeless tobacco? Yes No

Has the patient ever had heart trouble? Yes No If YES, Please describe _____

Does the patient require antibiotics before dental treatment? Yes No

Has the patient ever been treated for any of the following?

Arthritis Blood disorder Diabetes Tuberculosis Osteoporosis/Bone Loss

Asthma Blood pressure Epilepsy Cancer HIV/ AIDS

Are there any other medical or psychological considerations we should be aware of? Yes No

If YES, please explain _____

Dental History

Have there been any injuries to the face, mouth or chin? Yes No

Has the patient ever had pain/ tenderness in the jaw joint (TMJ/TMD)? Yes No

Does/ Did the patient ever have any of the following habits?

Grinding teeth Finger/ Thumb sucking Tongue Thrusting

Mouth Breathing Chewing/ Eating Problems Speech Problems

What is your biggest orthodontic concern at present? _____

Patient's attitude towards orthodontics? _____

Patient's Hobbies/ Interests: _____