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

Allergies

Aspirin	Nickel
Codeine	Penicillin
Latex	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	Mouth Breathing
Lip/Tongue Biting	Grinding Teeth
Nail Biting	Smoke/chew tobacco

Other _____

TMJ History (Jaw Joints)

Popping	Locking open
Clicking	Locking closed
Pain	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