# WILKE ORTHODONTICS LTD

PERSONALIZED ORTHODONTIC CARE

Person completing this report: ______________________ Today's Date: ____________________

## Medical and Dental History

Your careful and complete answers to the following questions are important.

Patient's Name: ________________________________________________ Birth Date: ______________
(Last) (First) (Middle)

## General Health Information

Name of patient's physician: _____________________________

Is patient currently under a physician's care, including pregnancy? If yes, describe medical condition(s): __________

_______________________________________________________________________________

Is pre-medication needed for dental appointments? ______________________________________

List all medications, drugs, or pills currently being taken: ______________________________

List any (drug, food, environmental) allergies or sensitivities: ____________________________

Has patient experienced any severe head or facial injuries, including trauma to the teeth? If "yes," please describe:

_______________________________________________________________________________

### Please check (✓) if you are presently or have been treated in the past for any of the following:

___ Heart problems
___ Heart murmur
___ Rheumatic fever
___ Diabetes
___ Arthritis
___ High blood pressure
___ Bleeding disorders
___ Venereal disease
___ AIDS
___ HIV

___ Benign tumors
___ Malignant tumors
___ Kidney problems
___ Glandular problems
___ Ulcers
___ Cancer
___ Hepatitis
___ Trauma
___ Latex allergy
___ TMJ (jaw joint problems)

___ Periodontal (gum) disease
___ Use of tobacco products
___ Emotional problems
___ Fainting or dizziness
___ Epilepsy
___ Urogenital disease
___ Convulsions / Seizures
___ Genetic disorders
___ Tuberculosis
___ Autism spectrum disorder

___ Sleep disorders
___ Breathing disorders
___ Asthma
___ Ear tubes placed
___ Tonsils removed
___ Adenoids removed
___ Glaucoma
___ Cleft lip or palate
___ Other (please explain on opposite page)

___ Previous orthodontic treatment if any, name of orthodontist: ______________________________

Member
American Association of
**Orthodontists**

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**Any medical condition, not mentioned on this form, for which you have been diagnosed and/or treated? Please explain:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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______________________________________________

**Please use this space for additional comments:**

______________________________________________

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______________________________________________

______________________________________________

______________________________________________

______________________________________________

## For Future Use

**Medical history or prescription changes:**

Comments: ______________________________________________

______________________________________________

Signed: ______________________ Date signed: ______________

*(Parent or Guardian)*

**Medical history or prescription changes:**

Comments: ______________________________________________

______________________________________________

Signed: ______________________ Date signed: ______________

*(Parent or Guardian)*

**Medical history or prescription changes:**

Comments: ______________________________________________

______________________________________________

Signed: ______________________ Date signed: ______________

*(Parent or Guardian)*