

Gronberg Orthodontics

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Health History

Initial Date ___/___/___

Update 1 ___/___/___

Update 2 ___/___/___

Medical History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling or Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS / HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsils Removed |
| <input type="checkbox"/> | <input type="checkbox"/> | Adenoids Removed |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Usage (Cigarettes___Smokeless___) |

Please list dates and specifics for all "Yes" answers: _____

List any allergies: _____

List medications presently being taken: _____

List any serious illness or operation not listed above: _____

Is the Patient currently under a physicians care? _____

Physician's Name _____

Reason _____

Dental History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any injury to face, mouth, teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Thumb, finger or lip sucking habit(s)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing when asleep, awake? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known missing permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known extra permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any teeth removed by extraction? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tongue thrust? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any wind instruments played? |
| <input type="checkbox"/> | <input type="checkbox"/> | Clenching or Grinding of teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronically sore or bleeding gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain, popping, grinding, locking? |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty chewing or swallowing food? |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches? If Yes, how frequent? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle tenderness or stiffness in neck/jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringling of ear, dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous treatment for TMJ or joint problems? |

Please list dates and specifics for all "Yes" answers: _____

Does patient visit his/her dentist regularly? _____

Has an Orthodontist been consulted previously? _____

Reason: _____

Has patient experienced a sudden increase in height?: _____

Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws? Explain _____

Please list any other dental information known, and not listed above: _____

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient/Parent/Guardian Signature _____ Date ___/___/___