James J. Tomassetti, DMD
Diplomate, American Board of Orthodontics

Edward Y. Lin, DDS, MS

Andrew W. Eichholz, DDS, MS

Your careful and complete answers to these questions are important. If additional space is needed, please use back of this form.

Medical & Dental History

Today's date: ____________________

Patient name: ____ Birth date: ____________________________________
(Last, First, Middle)

Address: ____________________________________ City: ___________________________ State:__________ZIP: __________

Home phone:________________________ Cell phone:________________________ Work phone: ________________________

Person completing this form: ____

General Health Information

Patient's physician: ____

Patient's dentist: ____

Is patient currently under a physician's care? If yes, describe medical condition: ________________________________

____

Is pre-medication needed for dental appointments? ____

____

____

List all medications/drugs/pills currently being taken: ____

____

____

List any allergies or sensitivities (drug/food/environmental): ____

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

____

Is there a mouth breathing or snoring habit?: ____

Do you ever wake up at night? ________ If so, how often? ____

Have you been diagnosed with sleep apnea? ____

Do you use a CPAP machine or wear a sleep appliance due to sleep apnea? ___________________________________

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Patient Name: ______________________________

Please check all boxes that apply 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
- ☐ Previous orthodontic treatment, name of orthodontist: ______________________________
- ☐ 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
- ☐ Sleep disorders
- ☐ Breathing disorders
- ☐ Asthma
- ☐ Ear tubes placed
- ☐ Tonsils removed
- ☐ Adenoids removed
- ☐ Glaucoma
- ☐ Cleft lip or palate
- ☐ Other (explain on next page)

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

____
____
____
____
____
____

Please use this space for additional information/comments:

____
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