

# Lustig 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            |

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** \_\_\_/\_\_\_/\_\_\_