Dr. Jay Zuroff Orthodontics

MEDICAL HISTORY: Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you (or your child), it is necessary to have the following information:

Patient Name_____ Parent/Guardian Name _____

HAVE YOU EVER HAD:	YES	NO
1. Asthma, hay fever, or allergic reaction to food, latex, metals, etc.		
2. Allergy to penicillin, aspirin, local or general anesthetic, or other drugs		
3. Blood pressure or heart problems		
4. Rheumatic fever or heart murmur		
5. A pacemaker or open heart surgery		
6. Diabetes, liver, kidney, thyroid, or lung problems		
7. Ulcers or stomach problems		
8. Hepatitis or Jaundice		
9. Epilepsy or nervous disorders		
10. To take antibiotics prior to dental appointments?		
11. Arthritis		
12. Venereal Disease, Herpes, AIDS		
13. Any other illness — Please describe:		
14. Are you presently taking any medicine? Specify:		
15. Have you ever been hospitalized? Specify:		
16. Women — are you pregnant?		

	YES	NO
1. When was your last dental cleaning? Who?		
2. Do you get nervous at dental appointments?		
3. Have you had trouble from previous dental care?		
4. Have you ever had pain in your jaw joint(s) or near your ears?		
5. Does your jaw make noise during opening or closing?		
6. Has your jaw ever locked open or closed?		
7. Does your jaw feel comfortable in your present bite?		
8. If your jaw joint(s) do bother you, how long ago did it start?		
9. Have you ever had an injury to your face or jaws?		
10. Have you ever had a "whiplash" accident?		
11. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
12. Does any part of your mouth hurt when clenched?		
13. Do your gums bleed?		
14. Have you ever had instructions on the care of your gums?		
15. Do you habitually clench or grind your teeth during the night or day?		

SIGNATURE DATE