Donald C. Demas, D.D.S., MS

Your answers to the following questions will be helpful in the planning of an adequate treatment.

Date: _____

Patient's Name: _____

Physician's Name: _____

YES NO

1. Is the patient presently under a physician's care . . . . . .
   Please explain: _____
2. Is this patient taking any medication ?. . . . . .
   Please list:
3. Has the patient ever had Rheumatic Fever? . . . . . .
   Heart disease/murmur? . . . . . .
   Diabetes? . . . . . .
   Asthma? . . . . . .
   Hay Fever? . . . . . .
   Allergies? . . . . . .
   Convulsions? . . . . . .
   any other problems? . . . . . .
4. Has the patient been ill for more than 5 days in the last year? . . . . . .
   Please explain: _____
5. Has the patient ever had any extensive X-ray therapy? . . . . . .
6. Has the patient been seen by a dentist in the last 12 months? . . . . . .
7. Has the patient ever had operations or injuries of the head or neck? . . . . . .
8. Has the patient ever received a severe blow to the teeth or jaws? . . . . . .
9. Does the patient constantly have sore or bleeding gums? . . . . . .
10. Has the patient had any teeth removed? . . . . . .
11. Does the patient brush his/her teeth in the morning? . . . . . .
    after lunch? . . . . . .
    after dinner? . . . . . .
    before retiring? . . . . . .
12. Does/did the patient ever suck fingers, thumb, lips or tongue . . . . . .
13. Does/did the patient bite his/her lips, tongue, fingernails, pencil or other objects?
14. Does the patient grit, grind or clench his/her teeth at night? . . . . . .
15. Have the tonsils and/or adenoids been removed? . . . . . .
16. Does the patient breathe through his/her mouth? . . . . . .
17. Does the patient play a musical instrument? . . . . . .
    Please list which instruments:
18. Is the patient concerned about the appearance of his/her teeth? . . . . . .
19. Has the patient ever been teased about the appearance of his/her teeth? . . . .

(Pease continue on flip side)

20. Is there any difficulty in chewing or swallowing food? . . . . . .
21. Is there clicking or snapping of the joint of the lower jaw when opening/closing the mouth? . . . .
22. Is the patient aware of/or concerned about his/her orthodontic problem? . . . . . .
23. Is the patient's attitude toward wearing orthodontic appliances one of eagerness?
    willingness? . . . . . .
    complacency? . . . . . .
    resignation? . . . . . .
    antagonism? . . . . . .
24. Does any member of the family or close relatives have similar arrangement of teeth or similar appearance of jaws?
25. Has any member of the family had orthodontic treatment? . . . . . .
26. Who first noticed the need for orthodontic treatment? . . . . . .
    Parents? . . . . . .
    Dentist? . . . . . .
    Patient? . . . . . .
    Other? . . . . . .
27. Are the parents interested in having orthodontic treatment for appearance?
    better digestion? . . . . . .
    better speech? . . . . . .
    on advice of dentist? . . . . . .
    on advice of friends? . . . . . .
28. Are the parents aware that appointments will infringe on minimal school time? . . . . . .
29. Has the patient experienced a sudden increase in height? . . . . . .
30. If the patient is male; has his voice changed? . . . . . .
    has he started to shave? . . . . . .
31. If the patient is female; has she started her menstrual cycle? . . . . . .

Patient's Current Weight: _____ Mother's Height: _____

Current Height: _____ Father's Height: _____

Sibling(s) / Age(s): _____

Patient's Hobbies/Interests:

Sports: _____

School: _____

_____ _____

Signature Date

THANK YOU

Donald C. Demas, D.D.S., MS

Your answers to the following questions will be helpful in the planning of adequate treatment.

Name: _____ Date of Birth: _____/ _____/ _____

Address: _____ Home Phone: _____

Social Security Number: _____- _____- _____

Patient Medical History

Physician: _____ Address:

_____

Approximate date of late exam: _____ Office Phone:

_____

Yes	No	(Please explain YES answers)
___	___	Are you under any medical treatment now?
___	___	Have you had any major operations? If so, what?
___	___	Have you ever had a serious accident involving head injuries?
___	___	Have you had any adverse response to any drugs including penicillin?
___	___	Has a physician ever informed you that you had any of the following:
___	___	A heat murmur? _____
___	___	A heart condition (ie. Mitral Valve Prolapse)? _____
___	___	Respiratory disease? _____
___	___	Diabetes? _____
___	___	Rheumatic Fever? _____
___	___	Rheumatism of Arthritis? _____
___	___	Tumors or growths? _____
___	___	Any blood disease? _____
___	___	Any liver disease? _____
___	___	Any kidney disease? _____
___	___	Any stomach or intestinal disease? _____
___	___	Any venereal disease? _____
___	___	Tested HIV positive? _____
___	___	Yellow Jaundice or Hepatitis? _____
___	___	Other? If so, what? _____
___	___	Do you have night sweats accompanied by weight loss or cough? _____
___	___	Are you on a diet at this time? _____
___	___	Are you now taking drugs or medications? If so, what? _____
___	___	Are you allergic to any known materials resulting in hives, asthma, eczema, etc? _____
___	___	Are you in general good health at this time? _____
___	___	Have any wounds healed slowly or presented any other complications? _____
___	___	Are you pregnant? _____
___	___	Do you have a history of fainting? _____

(Please continue on flip side)

Patient Dental History

Dentist: _____ Address: _____

Approximate of last cleaning: _____ Office Phone: _____

When was your last full mouth or panoramic x-ray taken? _____ Where? _____

___ ___ Do you have pain in or near yours ears? _____

___ ___ Do you habitually clench your teeth during the day and/or night? _____

___ ___ Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)

If so, which location: _____

Signature: _____ Date: _____