Varble Orthodontics- Zachary L. Varble DMD, MSD

All past medical and dental history may be important for optimal care. Please take time to be as accurate and thorough as possible in answering the following questions. THANK YOU.

Dental and Health History

Patient's Name: _____ Age: _____ Height: _____Weight: _____
Patient's Physician(s): _____ Date of last physical exam: _____
Patient's General Dentist(s): _____ Date of last dental cleaning: _____

Reason for seeking orthodontic advice:

[ ] Information
[ ] Treatment at this time
[ ] Clarification of previously received information or conflicting information
[ ] Continuation of treatment

A. What is your/ your child's chief concern: _____
_____
B. Describe any injuries or blows to your face, mouth or teeth: _____
_____
C. List all current medications including non-prescriptions: _____
_____
D. List all drug allergies: _____
_____
E. Do you have a latex allergy? (Circle one) Yes / No

Please mark all that apply

DENTAL

- o Treated for or told you have gum disease
- o Had any oral surgery
- o Sore teeth
- o Sore gums
- o Pain, popping, catching or locking in the jaw joints
- o Clench or grind your teeth
- o Wake up with sore jaws
- o Fever blisters or mouth ulcers
- o Suck your thumb, finger or lip? Past ___ Present ___
- o Speech Therapy? Past ___ Present ___
- o Treated or consulted for orthodontic therapy
- o Tooth sensitivity (hot, cold, sweets)
- o Gag easily
- o Tongue thrusting habit
- o History of TMJ (jaw joint) problems or therapy? Past ___ Present ___
- o Require antibiotics prior to dental procedures

MEDICAL

- o Any heart trouble, murmur or mitral valve prolapse
- o Prosthetic devices (heart, valve, hip, etc)
- o Asthma/ require an inhaler
- o Difficulty with instructions
- o Epilepsy, convulsions or seizures
- o Pregnant or possibly pregnant
- o Diabetes
- o Arthritis or rheumatism
- o Autism or autism spectrum
- o Cancer (type/date):
  _____
  _____
- o Any other serious illness/ailments not listed (list type/date):
  _____
  _____
  _____

Please expand on the above information or add anything you feel is important:

_____
_____
_____

The above information is accurate and complete to the best of my knowledge Patient or Guardian's Signature: _____