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*ORTHODONTICS FOR ADULTS AND CHILDREN*

Name: \_\_\_\_\_

Age: \_\_\_\_\_

**MEDICAL HISTORY**

Have you been diagnosed or treated for any of the following:

	YES	NO		YES	NO
Endocrine Problem			Epilepsy		
Rheumatic Fever			Blood Problem		
Diabetes			Fainting		
Kidney Disease			Heart Disease		
Bone Disorder			Hepatitis		
Arthritis			Emotional Problem		
			AIDS		

Is patient currently under the care of a physician? \_\_\_\_\_

If so, why? \_\_\_\_\_

Please describe any present or past medical problem, hospitalizations and operations. \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ To what? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_ If yes, what? \_\_\_\_\_

Do you consider yourself in good health? \_\_\_\_\_

(Women) Are you pregnant? \_\_\_\_\_ If yes, what trimester? \_\_\_\_\_

**DENTAL HISTORY**

Has the patient had any injuries to the face or head? \_\_\_\_\_

Has the patient ever had any teeth removed? \_\_\_\_\_

Does the patient have any problems with sore or bleeding gums? \_\_\_\_\_

Does the patient grind their teeth? \_\_\_\_\_ When? \_\_\_\_\_

Does the patient receive routine general dental care? \_\_\_\_\_

Has the patient had previous orthodontic consultation/treatment? \_\_\_\_\_

What is the patient's reason for seeking orthodontic treatment? \_\_\_\_\_

Please describe any other dental condition not mentioned above. \_\_\_\_\_

Signature of patient or parent: \_\_\_\_\_ Date \_\_\_\_\_