

Name and ages of brothers and sisters? _____

Have any had orthodontic treatment? _____

DENTAL HISTORY

Yes No

- ___ ___ Have you ever had any severe head or face injuries? Explain: _____
- ___ ___ Have you ever had a history of thumb sucking or finger sucking? ___ Stopped? ___ When?
- ___ ___ Do you play any musical (wind) instruments? ___ What? _____
- ___ ___ Have you consulted an orthodontist previously? _____
- ___ ___ Have you had any previous orthodontic treatment? _____
- ___ ___ Have any family members had orthodontic treatment? _____

Please check if there is a history of:

- ___ Clenching Teeth ___ Headaches (more than normal) ___ Jaw Joint Popping
- ___ Grinding Teeth ___ Jaw Joint Soreness ___ Ringing in the ears
- ___ Muscular Soreness around Head and Neck ___ Jaw Joint Clicking

Is there any other information that may be helpful? _____

Thank you

Signed: _____ Date: _____