Today's Date _____

Patient's Name _____ Sex _____ Date of Birth _____
Address _____ Postal Code _____
Phone Number(s) _____Sask. Hosp. #_____
Treaty # (if applicable) _____ Family Dentist _____
Family Physician _____ Referred by _____
Previous Orthodontic Treatment (if any) And By Whom _____

Parent's Name (if applicable) _____
Business Phone Number(s) _____
Other Children (age) _____

What do you wish to gain through treatment? _____

DENTAL HISTORY SUMMARY

Has patient received a blow to the teeth or jaw? _____
Does the patient have any problems with teeth or gums? _____
Does patient suck thumb or does patient grind teeth? _____
Any other relevant past dental history? _____

GENERAL PHYSICAL DEVELOPMENT

(Applicable if patient is still growing)

Height _____ Weight _____
Female Patients: Has patient started monthly period (if yes at what age)? _____
Male Patients: Has his voice changed (if yes at what age)? _____

PAST MEDICAL HISTORY

Please circle the following diseases where appropriate:

Chicken Pox	Asthma	Fainting spells	Frequent Colds/Coughs
Pneumonia	Diabetes	Positive HIV test	Heart Attack
Ear Aches	Allergies	Epilepsy (seizures)	Venereal Disease
Influenza	Typhoid	Kidney Disease	Adenoids Removed
Intestinal Upsets	Stroke	Jaundice (Hepatitis)	Thyroid Disease
Hemophilia (bleeder)	Scurvy	Rheumatic Fever	Tumor (cancer)
Frequent Headaches	Diptheria	Sore Throat	Tonsils Removed
Scarlet Fever	Measles	High Blood Pressure	Osteomyelitis
Whooping Cough	Mumps	Rickets	Bronchitis
Anemia	Eczema	Tuberculosis	Ulcer

Have you taken any medication in the past 3 weeks? _____
Have you been treated by a physician in the last year? _____
Do you get short of breath after mild exercise? _____
Do your ankles swell during the day? _____
Do you ever get pains in your chest or over your heart? _____
Is there anything wrong with your heart? _____
Have you ever been denied permission to give blood? _____
Have you ever had an operation or been a patient in a hospital? _____
Have you ever been sick in bed for more than 7 days? _____
Are you allergic to latex or any medicine? _____
Has a doctor ever told you that you have a heart murmur? _____
Do you urinate more often than you should? _____
Do you ever pass blood-stained (red) urine? _____
Are your stools ever black in color? _____
Have you ever experienced a period of rapid weight loss? _____
Have you ever experienced a period of rapid weight gain? _____
Are you thirsty or hungry much of the time? _____
Do you suffer from any disease or ailment not listed above? _____

SIGNATURE (relationship to patient)? _____