I. KEITH CORBETT, D. D. S., M. S.
Certified Specialist in Orthodontics

HEALTH HISTORY FORM

We would appreciate very much the following information to help us in providing a thorough orthodontic consultation.

1. Name _____ Nickname _____ Age _____
   Last First

2. Birthday _____ Sex _____ Phone _____

3. Home Address _____
   Street City Postal Code

4. Father's Name _____ Address: as above ___ OR _____ PH. _____

5. Mother's Name _____Address: as above ___ OR ___ PH. _____

6. Physician _____ When last visited _____

7. Dentist _____ When last visited _____

	CHECK ONE YES	NO
8. Do you have a health problem?	_____	_____
9. Are you under treatment by a physician?	_____	_____
10. Have you experienced any unfavourable reaction to any medicine such as penicillin, aspirin, barbituates, or local anesthetics?	_____	_____
11. Are you sensitive or allergic to anything?	_____	_____
12. Are you currently taking any medicine? If so, what _____	_____	_____
13. Do you have difficulty breathing through your nose?	_____	_____
14. Do you tend to breathe through your mouth while sleeping?	_____	_____
15. Have you ever been hospitalized? If so, at what age and for what reason?	_____	_____
Age _____ Reason _____		
16. Do you grit or grind your teeth during the day or night?	_____	_____
17. Have you had any previous orthodontic treatment? If yes, please explain	_____	_____
18. Have you ever had any bone, connective tissue (collagen) or hormonal abnormalities?	_____	_____
If yes, please explain _____	_____	_____
19. Have you ever had problems with your jaw joint: i. e. clicking, popping, pain?	_____	_____

Have you had any history of the following?:

YES	NO		YES	NO	
_____	_____	Heart trouble or congenital heart lesions	_____	_____	Fainting or dizziness
_____	_____	Asthma	_____	_____	Diabetes
_____	_____	Skin rash or hives	_____	_____	Tuberculosis
_____	_____	Kidney Involvement	_____	_____	Rheumatic fever
_____	_____	Hepatitis or liver involvement	_____	_____	Bleeding disorders
_____	_____	Epilepsy	_____	_____	Nervousness or hyperactivity
_____	_____	Radiation treatment	_____	_____	Anemia
_____	_____	Cold sores or "fever blisters"	_____	_____	Thyroid disorders
_____	_____	Malignancies	_____	_____	Mononucleosis
_____	_____	Hearing problems	_____	_____	Other _____