WILKE ORTHODONTICS LTD

PERSONALIZED ORTHODONTIC CARE

KEVIN J. WILKE, DDS, MS

Today's Date: _____

Medical and Dental History

Your careful and complete answers to the following questions are important. If you need additional space for any of your answers, please use the backside of this form.

Personal Information

Patient's Name: _____ Birth Date: _____
(Last) (First) (Middle)

Address: _____ City: _____ Zip: _____

Phone: (_____) _____ Person completing this report: _____

General Health Information

Name of patient's physician: _____ General dentist: _____

Is patient currently under a physician's care? If yes, describe medical condition(s): _____

_____

Is pre-medication needed for dental appointments? _____

List all medications, drugs, or pills currently being taken: _____

List any (drug, food, environmental) allergies or sensitivities: _____

Has patient experienced any severe head or facial injuries, including trauma to the teeth? If "yes," please describe:

_____

Please check (✓) if you are presently or have been treated in the past for any of the following:

___ Heart problems	___ Benign tumors	___ Periodontal (gum) disease	___ Sleep disorders
___ Heart murmur	___ Malignant tumors	___ Use of tobacco products	___ Breathing disorders
___ Rheumatic fever	___ Kidney problems	___ Emotional problems	___ Asthma
___ Diabetes	___ Glandular problems	___ Fainting or dizziness	___ Ear tubes placed
___ Arthritis	___ Ulcers	___ Epilepsy	___ Tonsils removed
___ High blood pressure	___ Cancer	___ Urogenital disease	___ Adenoids removed
___ Bleeding disorders	___ Hepatitis	___ Convulsions / Seizures	___ Glaucoma
___ Venereal disease	___ Trauma	___ Genetic disorders	___ Cleft lip or palate
___ AIDS	___ Latex allergy	___ Tuberculosis	___ Other (please explain on next page)
___ HIV	___ TMJ (jaw joint problems)		

___ Previous orthodontic treatment, name of orthodontist: _____

Member
American Association of
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