Jensen
ORTHODONTIC ARTS

DENTAL HISTORY

Check if you have or have had any of the following:

- ☐ Blisters on Lips/Mouth
- ☐ Burning Sensation, Tongue
- ☐ Congenitally Missing Teeth
- ☐ Dry Mouth
- ☐ Finger/Thumb Habits
- ☐ Food Gets Trapped
- ☐ Grinding/Clinching Teeth
- ☐ Gums Bleeding
- ☐ Gums Sore/Swollen
- ☐ Injuries to Teeth/Jaws
- ☐ Injuries to Face/Head
- ☐ Jaw Clicking/Popping
- ☐ Jaw Locking Open/Closed
- ☐ Jaw Pain/Tenderness
- ☐ Jaw Surgery
- ☐ Lip/Cheek Biting
- ☐ Loose Permanent Teeth
- ☐ Mouth Breathing
- ☐ Mouth Pain when Brushing
- ☐ Orthodontic Treatment
- ☐ Pain around Ear
- ☐ Periodontal Surgery
- ☐ Periodontal Treatment
- ☐ Sensitive to Hot or Cold
- ☐ Sensitive to Sweets
- ☐ Sensitive when Biting
- ☐ Sores/Growths in Mouth
- ☐ Speech Problems
- ☐ Tongue Thrust
- ☐ Snoring
- ☐ Sleep Apnea
- ☐ Complex Dental Issues

How often do you brush?_____ How often do you floss?_____

How would you rate your overall dental health? POOR 0 1 2 3 4 5 6 7 8 9 10 GREAT

Additional Comments:_____

MEDICAL HISTORY

Check if you have or have had any of the following:

- ☐ ADHD
- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Anxiety Issues
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valves
- ☐ Artificial Joint
- ☐ Asperger Syndrome
- ☐ Asthma
- ☐ Autism
- ☐ Back Problems
- ☐ Blood/Bone Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Disorder
- ☐ Coughing-Persistent
- ☐ Cough up Blood
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches/Migraines
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis A, B, or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous System Issues
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Stomach/Intestinal Disease
- ☐ Stomach Ulcer
- ☐ Swelling of Feet
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsils/Adenoids Removed
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Shortness of Breath
- ☐ Venereal Disease

Is it possible that you could be pregnant? Yes No How Long?_____ At what age did you/child start your menstrual cycle?_____

Are you under the care of a physician? Yes No For what condition?_____

Physician's Name:_____ Phone Number:_____

How would you rate your overall physical health? POOR 0 1 2 3 4 5 6 7 8 9 10 GREAT

Additional Comments:_____

MEDICATIONS

Please list any medications you are currently taking

_____

_____

ALLERGIES

Please list any known allergies you are aware of

_____

_____

Are you now or have you ever taken Bisphosphonates such as Actonel, Boniva, Didronel, Fosamax, or Zometa? Yes No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. It is my responsibility to inform this office of any changes in my medical status. I will not hold Dr. Douglas E. Jensen or his staff responsible of any errors or omissions that I have made in the completion of this form.

Name (Printed)	Signature	Date