Orthodontic Medical History

____

Patient Name DOB Date

For the following questions mark yes, no, or don't know/ understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

____ yes ____no ____ dk/u Does patient follow directions well?

____yes ____ no ____ dk/u Does patient brush his teeth 2x/day?
____yes ____ no ____ dk/u Does patient have learning disabilities or need extra help with instructions?
____yes ____no _____dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

____yes ____no ____dk/u Birth defects or hereditary problems?
____yes ____no ____dk/u Bone fractures, any major accidents?
____yes ____no ____dk/u Rheumatoid or arthritic conditions?
____yes ____no ____dk/u Endocrine or thyroid problems?
____yes ____no ____dk/u Kidney problems?
____yes ____no ____dk/u Diabetes?
____yes ____no ____dk/u Cancer, tumor, radiation treatment or chemotherapy?
____yes ____no ____dk/u Polio, mononucleosis, tuberculosis or pneumonia?
____yes ____no ____dk/u Problems of the immune system?
____yes ____no ____dk/u AIDS or HIV positive?
____yes ____no ____dk/u Hepatitis, jaundice or liver problems?
____yes ____no ____dk/u Fainting spells, seizures, epilepsy or neurological problems?
____yes ____no ____dk/u Mental health disturbance or behavioral problems?
____yes ____no ____dk/u Vision, hearing, tasting or speech difficulty?
____yes ____no ____dk/u Loss of weight recently, poor appetite?
____yes ____no ____dk/u History of eating disorder (anorexia, bulimia)?
____yes ____no ____dk/u Excessive bleeding or bruising tendency, Anemia or bleeding disorder?
____yes ____no ____dk/u High or low blood pressure?
____yes ____no ____dk/u Tires easily?
____yes ____no ____dk/u Chest pain, shortness of breath or swelling ankles?
____yes ____no ____dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
____yes ____no ____dk/u Skin disorder?
____yes ____no ____dk/u Frequent headaches, colds or sore throat?
____yes ____no ____dk/u Eye, ear, nose or throat condition?
____yes ____no ____dk/u Hay fever, asthma, sinus trouble or hives?
____yes ____no ____dk/u Tonsil or Adenoid Condition?

Allergies or reactions to any of the following:

____yes ____no ____dk/u Local anesthetics (Novocain or Lidocaine)
____yes ____no ____dk/u Aspirin
____yes ____no ____dk/u Ibuprofen (Motrin, Advil)
____yes ____no ____dk/u Penicillin or other antibiotics
____yes ____no ____dk/u Sulfa Drugs
____yes ____no ____dk/u Codeine or other narcotics
____yes ____no ____dk/u Metals (jewelry, clothing snaps)
____yes ____no ____dk/u Latex (gloves, balloons)
____yes ____no ____dk/u Vinyl
____yes ____no ____dk/u Acrylic
____yes ____no ____dk/u Animals
____yes ____no ____dk/u Food (specify)____________________
____yes ____no ____dk/u Other substances (specify)

____

____yes ____no ____dk/u Has the patient taken a Biophosphate Derivative?
____yes ____no ____dk/u Is the patient taking medication, nutrient supplements, herbal medica-tions or nonprescription medicine?

Please name them.
Medication ______________ Taken for ________________
Medication Taken for ________________
Medication ______________ Taken for ________________

____yes ____no ____dk/u Does the patient currently have or ever had a substance abuse problem?
____yes ____no ____dk/u Does the patient chew or smoke tobacco?
____yes ____no ____dk/u Surgeries? Describe ____________
____yes ____no ____dk/u Hospitalized? For ______________
____yes ____no ____dk/u Other physical problems or symptoms? Describe:
____yes ____no ____dk/u Being treated by another health care professional? For______________

Date of last physical exam:
Are there any other medical conditions that we should be aware of? List:

GIRLS ONLY

____yes ____no ____dk/u Has the patient started her monthly period?If so, at what age?__________

____yes ____no ____dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Does the patient's parents or siblings have any of the following:
Health problems? If so, please explain.
Bleeding Disorder ______________________________
Diabetes ______________________________
Arthritis ______________________________
Metabolic Disturbances ______________________________
Severe Allergies ______________________________
Unusual dental problems ______________________________
Jaw size imbalance ______________________________
Autism?______________________________
Are there any other family medical conditions that we should know about? ______________________________

DENTAL HISTORY

Now or in the past, has the patient had:

____yes ____no ____dk/u Started teething very early or late?
____yes ____no ____dk/u Primary (baby) teeth removed that were not loose?
____yes ____no ____dk/u Permanent or supernumerary "extra" teeth removed?
____yes ____no ____dk/u Supernumerary "extra" or congenitally missing teeth?
____yes ____no ____dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
____yes ____no ____dk/u Teeth sensitive to hot or cold; teeth throb or ache?
____yes ____no ____dk/u Jaw fractures, cysts or mouth infections?
____yes ____no ____dk/u "Dead teeth" or root canals treated?
____yes ____no ____dk/u Bleeding gums, bad taste or mouth odor?
____yes ____no ____dk/u Periodontal "gum problems"?
____yes ____no ____dk/u Food impaction between teeth?
____yes ____no ____dk/u Thumb, finger or sucking habit? Until what age? ________
____yes ____no ____dk/u Tongue thrust?
____yes ____no ____dk/u History of speech problems?
____yes ____no ____dk/u Mouth breathing habit, snoring or difficulty breathing?
____yes ____no ____dk/u Tooth grinding, jaw clenching, clicking or locking?
____yes ____no ____dk/u Any pain in jaw or ringing in ears?
____yes ____no ____dk/u Any pain or soreness in the muscles of the face or around the ears?
____yes ____no ____dk/u Difficulty encountered in chewing or jaw opening?
____yes ____no ____dk/u Aware of loose, broken or missing restorations?
____yes ____no ____dk/u Any teeth irritating cheek, lip, tongue or palate?
____yes ____no ____dk/u Concerned about spaced, crooked or protruding teeth?
____yes ____no ____dk/u Aware or concerned about under or over developed jaw?
____yes ____no ____dk/u "Gum boils" frequent canker sores or cold sores?
____yes ____no ____dk/u Taking any forms of fluoride?
____yes ____no ____dk/u Any relative with similar tooth or jaw relationships?
____yes ____no ____dk/u Had periodontal (gum) treatment?
____yes ____no ____dk/u Would patient object to wearing appliances (braces) should they be indicated?
____yes ____no ____dk/u Ever had a prior orthodontic examination or treatment?
____yes ____no ____dk/u Been under another dentist's care?
Specialist ____________________
Other ____________________

What is your primary concern? Why are you here? ____

I have read and understand the above questions. I will not hold the Orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed____ Date________________________
(Patient or Parent/Guardian if Patient is under 18)

Signed____ Date________________________
(Doctor)

Updates:

Date:	Changes in Health:	Parent/Guardian Signature	Dr. Initials
________	______________________________	______________________________	____________
________	______________________________	______________________________	____________
________	______________________________	______________________________	____________

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