

Patient's Name: _____ Date: _____

Name Of Patient's Physician: _____ Phone #: (_____) _____ - _____

Physician's Address: _____

City: _____ State: _____ Zip Code: _____

Date Last Seen: _____ Reason: _____

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.**

MEDICAL HISTORY

Now or in the past have you had:

1. yes no dk/u Birth defects or hereditary problems?
2. yes no dk/u Bone fractures or any major accidents?
3. yes no dk/u Back or neck problems?
4. yes no dk/u Rheumatoid or arthritic conditions?
5. yes no dk/u Artificial joints, disk replacements?
6. yes no dk/u Endocrine or thyroid problems?
7. yes no dk/u Kidney problems?
8. yes no dk/u Diabetes?
9. yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
10. yes no dk/u Stomach ulcer or acidity?
11. yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
12. yes no dk/u Persistent cough, cough up blood?
13. yes no dk/u Problems of the immune system?
14. yes no dk/u AIDS or HIV positive?
15. yes no dk/u History of blood transfusion?
16. yes no dk/u Blood disorder or disease?
17. yes no dk/u Hepatitis, jaundice or liver problem?
18. yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
19. yes no dk/u Mental health disturbance or depression?
20. yes no dk/u Vision, hearing, tasting or speech difficulties?
21. yes no dk/u Loss of weight recently, poor appetite?
22. yes no dk/u History of eating disorder? (anorexia/bulimia)?
23. yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
24. yes no dk/u High or low blood pressure?
25. yes no dk/u Tires easily?
26. yes no dk/u Chest pain, shortness of breath or swelling ankles?
27. yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
28. yes no dk/u Pacemaker, defibrillator, artificial heart valve?
29. yes no dk/u Skin disorder?
30. yes no dk/u Does the patient eat a well-balanced diet?
31. yes no dk/u Frequent headaches, colds or sore throats?
32. yes no dk/u Eye, ear, nose or throat condition?
33. yes no dk/u Hay fever, asthma, sinus trouble or hives?
34. yes no dk/u Respiratory disease?

35. yes no dk/u Tonsil or adenoid conditions?

36. yes no dk/u Osteoporosis?

If YES to any of the above, note # and explain: _____

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 Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does patient chew or smoke tobacco?
- yes no dk/u Operations? Describe: _____
- yes no dk/u Hospitalized? For: _____
- yes no dk/u Other physical problems or symptoms? Describe: _____

yes no dk/u Are you taking medications, nutrient supplements, herbal medications or non-prescription medicine?

Please name them:

Medication _____	Taken for _____
Medication _____	Taken for _____
Medication _____	Taken for _____
Medication _____	Taken for _____
Medication _____	Taken for _____

yes no dk/u Being treated by another health care professional? (including psychological, or mental health issues? For: _____

Date of most recent visit? _____

Are there any other medical conditions we should be aware of? _____

Present Weight: _____ lbs. Height: _____ ft. _____ in.

WOMEN ONLY

yes no dk/u Are you anticipating becoming pregnant?

yes no dk/u Are you pregnant?

FAMILY MEDICAL HISTORY

Do your parents or siblings have any of the following health problems?
If so, please explain:

- Bleeding disorders _____
- Diabetes _____
- Arthritis _____
- Metabolic disturbances _____
- Severe allergies _____
- Unusual dental problems _____
- Jaw size imbalance _____
- Congenitally missing teeth _____
- Root resorption _____
- Any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past have you had:

- 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 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 History of jaw or mouth surgery?
- yes no dk/u Growths in mouth?
- yes no dk/u "Dead teeth" or root canals treated?
- yes no dk/u Root resorption?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Periodontal "gum problems"?
- yes no dk/u Receding gums?
- yes no dk/u Food impaction between teeth?
- yes no dk/u "Gum Boils", frequent canker sores or cold sores?
- yes no dk/u Thumb, finger, or sucking habit?

- Until what age? _____
- yes no dk/u Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u History of speech problems?
- yes no dk/u Mouth breathing habit, snoring or difficulty in breathing?
- yes no dk/u Tooth grinding or jaw clenching?
- yes no dk/u Any pain, clicking or locking in jaw or ringing in the 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 have you ever been treated for "TMD" or "TMJ" problems?
- yes no dk/u Aware of loose, broken or missing restorations (fillings)?
- 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 Any relative with similar tooth or jaw relationships?
- yes no dk/u Had periodontal (gum) treatment?
- yes no dk/u "Gum Boils", frequent canker sores or cold sores?
- yes no dk/u Any serious trouble related to previous dental treatment?
- yes no dk/u Any wisdom tooth problems?
- yes no dk/u Have any wisdom teeth been removed? When? _____
- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Have you been under another dentist's care?
Specialist _____
Other _____
- yes no dk/u Do you wear other orthodontic appliances (Retainers or night guard?)

Name Of Patient's Dentist: _____ Phone #: (_____) _____ - _____
 Dentist's Address: _____
 Date Last Seen: _____ Reason: _____

How often do you brush? _____ Floss? _____

What is your primary concern? Why are you here? _____
 I am interested in: Orthodontic treatment Clear braces Invisalign treatment Whitening Retainers Other _____

I have read and understand the above questions. I will not hold my orthodontist or any other member or 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 signed: _____
(Parent or Guardian)

Signed: _____ Date signed: _____
(Dental Staff Member)