Dr. Karen E. Calef
211 Storrs Rd. Mansfield, CT 06250 **(860) 456-3718** **www.smilesbykaren.com**

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 value?
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)