



Patient's Name: _____ **Birth Date:** _____ **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/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

- yes no dk/u Skin disorder?
- 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 Operations? Describe: _____
- yes no dk/u Hospitalized? Describe: _____
- yes no dk/u Other physical problems or symptoms? Describe: _____

MEDICAL HISTORY

Now or in the past, have you had:

- 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 Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis, 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 problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, tasting, or speech difficulties?
- 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 Tire easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?

- yes no dk/u Being treated by another health care professional? For: _____ Date of most recent physical exam? _____

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

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine 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 Foods (specify) _____
- yes no dk/u Other substances (specify) _____
- yes no dk/u Is the patient taking or have ever taken any oral or intravenous bisphosphonates or serious bone dis-orders/cancers, osteoporosis, osteopenia, or other uses? If so, please name below:

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

yes no dk/u Is the patient taking medication, nutrient supplement herbal medications or non-prescription medicine? If so, please name below:

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

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 "extra" (supernumerary) 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 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 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 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 "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 you object to wearing orthodontic appliances (braces) should they be indicated?
- yes no dk/u Any serious trouble associated with any previous dental treatment?
- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Been under another dentist's care? Specialist _____ Other _____

GIRLS ONLY

- yes no dk/u Has the patient started her monthly periods? If so, approximately when? _____
- yes no dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parent 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 _____

Any other family medical conditions that we should know about? _____

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

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

Date Signed: _____

Signed: _____
(Orthodontist)

Date Signed: _____