Medical and Dental History

PATIENT

Patient: **Prefers to be called:** **SSN:**
Sex: **Birthday:** **Age:** **Ethnicity:**
Home #: **Cell #:** **Work #:**
Address:
Email:

Years at above address: **If less than 5 years, previous address:**

Occupation:

IF UNDER 18

Does patient follow directions well? ☐ Yes ☐ No

Brush his/her teeth conscientiously? ☐ Yes ☐ No

Sensitive or self-conscious about teeth? ☐ Yes ☐ No

Started teething very early or late? ☐ Yes ☐ No

Primary teeth removed that weren't loose? ☐ Yes ☐ No

Taking any forms of fluoride? ☐ Yes ☐ No

Learning disabilities or need extra help? ☐ Yes ☐ No

Grade in school: _____

Hobbies and/or sports: _____

Musical instruments played: _____

Brothers and sisters: _____

Other family members treated here: _____

Patient's present height: _____

Birth father's height: _____

Birth mother's height: _____

Patient's birth weight: _____

Patient's present weight: _____

DENTAL HISTORY

NOW OR IN THE PAST, HAVE YOU HAD (circle choices):

- **Permanent or supernumerary teeth removed:** Yes No Don't Know
- **Supernumerary or congenitally missing teeth:** Yes No Don't Know
- **Chipped or injured primary or permanent teeth:** Yes No Don't Know
- **Teeth sensitive to hot or cold? Toothache?** Yes No Don't Know
- **Jaw fractures, cysts or mouth infections:** Yes No Don't Know
- **"Dead teeth" or root canals treated:** Yes No Don't Know
- **Bleeding gums, bad taste or mouth odor:** Yes No Don't Know
- **Periodontal "gum problems":** Yes No Don't Know
- **Food impaction between teeth:** Yes No Don't Know
- **"Gum boils", frequent canker sores or cold sores:** Yes No Don't Know
- **Thumb, finger, or sucking habit?** Yes No Don't Know
- **Abnormal swallowing habit (tongue thrusting):** Yes No Don't Know
- **History of speech problems:** Yes No Don't Know
- **Mouth breathing habit, snoring or difficulty in breathing:** Yes No Don't Know
- **Tooth grinding or jaw clenching:** Yes No Don't Know
- **Any pain, clicking or locking in jaw or ringing in the ears:** Yes No Don't Know
- **Any pain in facial muscles or around ears:** Yes No Don't Know
- **Difficulty in chewing or jaw opening:** Yes No Don't Know
- **Treatment for "TMD" or "TMJ" problems:** Yes No Don't Know
- **Aware of loose, broken or missing restorations (fillings):** Yes No Don't Know
- **Any teeth irritating cheek, lip, tongue or palate:** Yes No Don't Know
- **Concerned about spaced, crooked or protruding teeth:** Yes No Don't Know
- **Concerned about under or over developed jaw:** Yes No Don't Know
- **Any relative with similar tooth or jaw relationships:** Yes No Don't Know
- **Any wisdom tooth problems:** Yes No Don't Know
- **Had periodontal (gum) treatment:** Yes No Don't Know
- **Any serious trouble with prior dental treatment:** Yes No Don't Know
- **Been under another dentist's care:** Yes Dr. _____ No
- **Ever had a prior orthodontic examination or treatment:** Yes No Don't Know
- **Would you object to wearing braces:** Yes No Don't Know
- **How often do you brush:** _____
- **How often do you floss:** _____
- **What is your primary concern - why are you here:** -

_____

_____

MEDICAL HISTORY

NOW OR IN THE PAST, HAVE YOU HAD:

- **Birth defects or hereditary problems:**
  Yes explain:_____ No Don't Know
- **Bone fractures or any major accidents:**
  Yes explain:_____ No Don't Know
- **Rheumatoid or arthritic conditions:**
  Yes explain:_____ No Don't Know
- **Endocrine or thyroid problems:**
  Yes explain:_____ No Don't Know
- **Kidney problems:**
  Yes explain:_____ No Don't Know
- **Diabetes:**
  Yes explain:_____ No Don't Know
- **Malignancy:**
  Yes explain:_____ No Don't Know
- **Stomach ulcer or hyperacidity:**
  Yes explain:_____ No Don't Know
- **Polio, mononucleosis, tuberculosis, pneumonia:**
  Yes explain:_____ No Don't Know
- **Problems of the immune system:**
  Yes explain:_____ No Don't Know
- **AIDS or HIV positive:**
  Yes explain:_____ No Don't Know
- **Hepatitis, jaundice or liver problem:**
  Yes explain:_____ No Don't Know
- **Neurological problem:**
  Yes explain:_____ No Don't Know
- **Mental health disturbance or depression:**
  Yes explain:_____ No Don't Know
- **Vision, hearing, tasting or speech difficulties:**
  Yes explain:_____ No Don't Know
- **Recent loss of weight or poor appetite:**
  Yes explain:_____ No Don't Know
- **History of eating disorder (anorexia, bulimia):**
  Yes explain:_____ No Don't Know
- **Blood disorder:**
  Yes explain:_____ No Don't Know
- **High Blood pressure:**
  Yes explain:_____ No Don't Know
- **Tire easily:**
  Yes explain:_____ No Don't Know
- **Chest pain, shortness of breath or swelling ankles:**
  Yes explain:_____ No Don't Know
- **Cardiovascular problem:**
  Yes explain:_____ No Don't Know
- **Skin disorder:**
  Yes explain:_____ No Don't Know
- **Do you eat a well-balanced diet:**
  Yes explain:_____ No Don't Know
- **Frequent headaches, colds or sore throat:**
  Yes explain:_____ No Don't Know
- **Eye, ear, nose or throat condition:**
  Yes explain:_____ No Don't Know
- **Hayfever, asthma, sinus trouble or hives:**
  Yes explain:_____ No Don't Know
- **Tonsil or adenoid conditions:**
  Yes explain:_____ No Don't Know
- **Osteoporosis:**
  Yes explain:_____ No Don't Know

WOMEN ONLY:

Are you pregnant:
Yes, how far along_____ No Don't Know

Are you anticipating becoming pregnant:

If under 18, have you started your monthly periods:

FAMILY MEDICAL HISTORY (PARENTS & SIBLINGS):

ALLERGIES OR REACTIONS:

MEDICATIONS, NUTRIENT SUPPLEMENTS, HERBAL MEDICATIONS (please list all):

Do you currently have or ever had a substance abuse problem:
Yes _____ No

Do you chew or smoke tobacco:
Yes No

Operations: _____
Hospitalizations: _____
Other physical problems or symptoms: _____
_____

Being treated by another health care professional: _____
Date of most recent physical exam? _____
Last seen by physician:

Do you have any other medical conditions that we should know about:
_____
_____

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.

Patient/Guardian Date

Witness Date

Signatory verifies he/she can legally sign this form. If this is not signed by the patient, please fill out the information below:

Name:
Relationship to Patient: