

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:

- 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 Tired 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 throats?
- yes no dk/u Eye , ear, nose or throat condition?
- yes no dk/u Hayfever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adeniod conditions?
- yes no dk/u Osteoporosis?

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocane)
- 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, ballons)
- 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 Are you taking medication, 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 _____
- Medication _____ Taken for _____
- Medication _____ Taken for _____

yes no dk/u Do you currently have or ever had a substance abuse problem?

yes no dk/u Do you chew or smoke tobacco?

yes no dk/u Operations? Describe: _____

yes no dk/u Hospitalized? For: _____

yes no dk/u Being treated by another health care professional?

For: _____

Date of most recent physical exam? _____

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

WOMEN ONLY

yes no dk/u Are you pregnant?

yes no dk/u Are you anticipating becoming pregnant?

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

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

DENTAL HISTORY

Now or in the past, have you had:

- | | |
|--|--|
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Permanent teeth removed? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any pain or soreness in the muscles of the face or around the ears? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Supernumerary (extra) or congenitally missing teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Difficulty in chewing or jaw opening? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Chipped or otherwise injured primary (baby) or permanent teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Have you ever been treated for "TMD" or "TMJ" problems? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Teeth sensitive to hot or cold; teeth throb or ache? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Aware of loose, broken or missing restorations (fillings)? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Jaw fractures, cysts or mouth infections? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any teeth irritating cheek, lip, tongue or palate? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u "Dead teeth" or root canals treated? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Concerned about spaced, crooked or protruding teeth? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Bleeding gums, bad taste or mouth odor? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Aware or concerned about under or over developed jaw? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Periodontal "gum problems"? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any relative with similar tooth or jaw relationships? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Food impaction between teeth? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any wisdom tooth problems? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u "Gum boils", frequent canker sores or cold sores? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Had periodontal (gum) treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Thumb, finger, or sucking habit? Until what age ____? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Had any serious trouble associated with any previous dental treatment? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Abnormal swallowing habit (tongue thrusting)? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Been under another dentist's care? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u History of speech problems? | Specialist _____ |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Mouth breathing habit, snoring or difficulty in breathing? | Other _____ |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Tooth grinding or jaw clenching? | <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated? |
| <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> dk/u Any pain, clicking or locking in jaw ringing in the ears? | |

Has anyone else in your family been treated at this office? _____ Name _____

Dentist _____ Date last seen? _____ Reason _____

Referred By _____

Physician _____ Date last seen? _____ Reason _____

Have you seen another orthodontist? _____ Name _____

What do you want to see accomplished orthodontically? _____

How often do you brush: _____ floss: _____

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 the staff responsible for any errors or omissions that I have made in 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: _____

(Patient)