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 Name _____Date of Birth_____

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 extra help with instructions?
❒yes ❒no❒dk/u Is patient sensitive or self-conscious about teeth?

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 insuffiiciency, arterioslerosis, 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?

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 Other physical problems or symptoms?
Describe:_____
❒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 be aware of? _____

GIRLS ONLY

❒yes ❒no❒dk/u Is the patient 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:

❑yes ❑no❑dk/u Permanent 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 "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 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 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 Any wisdom tooth problems?
❑yes ❑no❑dk/u Had periodontal (gum) treatment?
❑yes ❑no❑dk/u Had any serious trouble associated with any previous dental treatment?
❑yes ❑no❑dk/u Been under another dentist's care?
Specialist _____
Other _____
❑yes ❑no❑dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

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/Guardian Signiture