CONFIDENTIAL DATE_____

DENTAL MEDICAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's Name_____Sex _____ Age_____

DOB_____ Home Phone Number_____ E-Mail_____

Address_____City_____ Zip_____

Any Siblings? _____ Ages_____

Other Family Members Treated_____

School_____ Grade_____ Musical Instrument Played_____

Sports/Hobbies_____

Present Height_____ Weight_____

Name of Dentist_____ Date of Last Check-Up_____

Whom may we thank for referring you?_____

Parent is (circle one) Single Married Widowed Separated Divorced

Resp. Party Name: _____Spouse's Name_____

Resp. Party Address_____ City_____ Zip_____

Home Number_____Work Number_____ Cell Number_____

E-Mail_____ Father's Height_____ Mother's Height_____

Parent/Guardian Name (if different from above)_____

Home Number_____Work Number_____ Cell Number_____

Emergency Contact Name & Number_____ Relationship_____

Dental Insurance Company_____ Subscriber Name:_____

SSN_____ DOB_____Employer_____ Work Phone Number _____

Work Address_____City_____ Zip_____

For the following questions, circle **yes**, **no**, or **don't know/understand**. The answers are for office records only and will remain confidential. A thorough and complete history is vital for a proper orthodontic evaluation.

Yes No DK/U Does patient follow directions?

Yes No DK/U Does patient brush his/her teeth consistently?

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?

MEDICAL HISTORY
If you answer yes to the following questions, please elaborate (if needed) in the space given.

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 or been treated for a tumor?

Yes No DK/U Stomach ulcer or hyperacidity?

Yes No DK/U Polio, mono, tuberculosis?

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 neurologic problems

Yes No DK/U Mental health or behavioral problems?

Yes No DK/U Vision, hearing, tasting, or speech difficulties?

Yes No DK/U Loss of weight recently, poor appetite?

Yes No DK/U Excessive bleeding, black & blue tendency, anemia, or bleeding disorder

Yes No DK/U High or low blood pressure?

Yes No DK/U Tires 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 disease or rheumatic heart)?

Yes No DK/U Skin disorders?

Yes No DK/U Do you have a normal and good diet?

Yes No DK/U Eye, ear, nose, throat condition?

Yes No DK/U Hayfever, asthma, sinus trouble, hives?

Yes No DK/U Tonsil, or adenoid conditions?

Yes No DK/U Allergies? Please name them.

_____

_____

Yes No DK/U Known reactions to any drugs? Please name them.

_____

_____

Yes No DK/U Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

_____

_____

Yes No DK/U Does the patient currently have or ever had a substance abuse problem?

Yes No DK/U Operations or surgical procedures?

Yes No DK/U Hospitalized for?_____

Yes No DK/U Other physical problems or symptoms?

Yes No DK/U Being treated by another health care professional? For_____

Date of Most Recent Exam_____

DENTAL HISTORY

Yes No DK/U Started teething very early or late?

Yes No DK/U Baby teeth removed that were not loose?

Yes No DK/U Permanent supernumerary teeth removed?

Yes No DK/U Supernumerary or congenitally missing teeth?

Yes No DK/U Chipped or injured baby or permanent tooth?

Yes No DK/U Teeth sensitive to hot or cold; teeth throb or ache?

Yes No DK/U Jaw fractures, cysts, mouth infections?

Yes No DK/U "Dead teeth", root canals treated?

Yes No DK/U Bleeding gums, bad taste, mouth odor?

Yes No DK/U Periodontal "gum problems"?

Yes No DK/U Food impactions between teeth?

Yes No DK/U "Gum boils", frequent canker sores?

Yes No DK/U Is child taking any forms of fluoride?

Yes No DK/U Thumb, finger, sucking habit? Until 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, difficulty in breathing?

Yes No DK/U Tooth grinding, jaw clinching, clicking, locking?

Yes No DK/U Any pain in jaw or ringing in the ears?

Yes No DK/U Does the patient experience 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 Any teeth irritating cheek, lip tongue, palate?

Yes No DK/U Concerned about spaced, crooked, or protruding teeth?

Yes No DK/U 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 Has patient had any serious trouble associated with any previous dental treatment?

Yes No DK/U Onset of puberty (approx. date) _____

Yes No DK/U Has patient ever had a prior orthodontic evaluation or treatment?

Yes No DK/U Has patient recently been under another dentist's care?
Specialist_____

Other_____

Yes No DK/U Has patient ever had periodontal (gum) treatment?

Yes No DK/U Would patient object to wearing orthodontic appliances should they be indicated?

Date of most recent examination_____

How often does patient brush_____ Floss _____

What is the patient's or parent's primary concern – Why are you here?

_____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointment, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

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 dental/medical status I will so inform this practice

_____

Signature of parent or guardian Date

Medical History Update or Changes: Date: Comments: Signature:

_____

_____

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_____