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 (select 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_____

Primary Insurance Company_____ Subscriber Name:_____

SSN_____ DOB_____Employer_____ Work Phone Number _____

Work Address_____City_____ Zip_____

For the following questions, select **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?
☐	☐	☐	Does patient brush his/her teeth consistently?
☐	☐	☐	Does patient have learning disabilities or need extra help with instructions?
☐	☐	☐	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?
☐	☐	☐	Bone fractures, any major accidents?
☐	☐	☐	Rheumatoid or arthritic conditions?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Kidney problems?
☐	☐	☐	Diabetes?
☐	☐	☐	Cancer or been treated for a tumor?
☐	☐	☐	Stomach ulcer or hyperacidity?
☐	☐	☐	Polio, mono, tuberculosis?
☐	☐	☐	Problems of the immune system?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or liver problems
☐	☐	☐	Fainting spells, seizures, epilepsy, or neurologic problems

Yes No DK/U

- ☐ ☐ ☐ Mental health or behavioral problems?
- ☐ ☐ ☐ Vision, hearing, tasting, or speech difficulties?
- ☐ ☐ ☐ Loss of weight recently, poor appetite?
- ☐ ☐ ☐ Excessive bleeding, black & blue tendency, anemia, or bleeding disorder
- ☐ ☐ ☐ High or low blood pressure?
- ☐ ☐ ☐ Tires easily?
- ☐ ☐ ☐ Chest pain, shortness of breath, or swelling ankles?
- ☐ ☐ ☐ Cardiovascular problem (heart trouble, heart attack angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart disease or rheumatic heart)?
- ☐ ☐ ☐ Skin disorders?
- ☐ ☐ ☐ Do you have a normal and good diet?
- ☐ ☐ ☐ Eye, ear, nose, throat condition?
- ☐ ☐ ☐ Hayfever, asthma, sinus trouble, hives?
- ☐ ☐ ☐ Tonsil, or adenoid conditions?
- ☐ ☐ ☐ Allergies or drug reactions?
- ☐ ☐ ☐ Are you taking medication, nutrient supplements or non prescription medicine? Please name them.

_____

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- ☐ ☐ ☐ Does the patient currently have or ever had a substance abuse problem?
- ☐ ☐ ☐ Operations or surgical procedures?
- ☐ ☐ ☐ Hospitalized for?_____
- ☐ ☐ ☐ Other physical problems or symptoms?
- ☐ ☐ ☐ Being treated by another health care professional? For_____
- ☐ ☐ ☐ Date of Most Recent Exam_____

DENTAL HISTORY

- ☐ ☐ ☐ Started teething very early or late?
- ☐ ☐ ☐ Baby teeth removed that were not loose?
- ☐ ☐ ☐ Permanent supernumerary teeth removed?
- ☐ ☐ ☐ Supernumerary or congenitally missing teeth?
- ☐ ☐ ☐ Chipped or injured baby or permanent tooth?
- ☐ ☐ ☐ Teeth sensitive to hot or cold; teeth throb or ache?
- ☐ ☐ ☐ Jaw fractures, cysts, mouth infections?
- ☐ ☐ ☐ "Dead teeth", root canals treated?
- ☐ ☐ ☐ Bleeding gums, bad taste, mouth odor?
- ☐ ☐ ☐ Periodontal "gum problems"?
- ☐ ☐ ☐ Food impactions between teeth?
- ☐ ☐ ☐ "Gum boils", frequent canker sores?
- ☐ ☐ ☐ Is child taking any forms of fluoride?
- ☐ ☐ ☐ Thumb, finger, sucking habit? Until Age_____
- ☐ ☐ ☐ Abnormal swallowing habit (tongue thrusting)?
- ☐ ☐ ☐ History of speech problems?

Yes No DK/U

- ☐ ☐ ☐ Mouth breathing habit, snoring, difficulty in breathing?
- ☐ ☐ ☐ Tooth grinding, jaw clinching, clicking, locking?
- ☐ ☐ ☐ Any pain in jaw or ringing in the ears?
- ☐ ☐ ☐ Does the patient experience any pain or soreness in the muscles of the face or around the ears?
- ☐ ☐ ☐ Difficulty encountered in chewing or jaw opening?
- ☐ ☐ ☐ Any teeth irritating cheek, lip tongue, palate?
- ☐ ☐ ☐ Concerned about spaced, crooked, or protruding teeth?
- ☐ ☐ ☐ Concerned about under or over developed jaw?
- ☐ ☐ ☐ Any relative with similar tooth or jaw relationships?
- ☐ ☐ ☐ Any wisdom tooth problems?
- ☐ ☐ ☐ Has patient had any serious trouble associated with any previous dental treatment?
- ☐ ☐ ☐ Onset of puberty (approx. date) _____
- ☐ ☐ ☐ Has patient ever had a prior orthodontic evaluation or treatment?
- ☐ ☐ ☐ Has patient recently been under another dentist's care? Specialist_____

  Other_____
- ☐ ☐ ☐ Has patient ever had periodontal (gum) treatment?
- ☐ ☐ ☐ 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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