

For the following questions please mark yes, no or don't know (d/k). 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 Profile:

- yes no d/k Does patient follow directions well?
- yes no d/k Does patient brush his/her teeth conscientiously?
- yes no d/k Does patient have learning disabilities or need extra help with instructions?
- yes no d/k Is patient sensitive or self conscience of teeth?

Medical History:

Now or in the past has the patient had:

- yes no d/k Birth defects or heredity problems?
- yes no d/k Bone fractures, any major accidents?
- yes no d/k Rheumatoid or arthritic conditions?
- yes no d/k Endocrine or thyroid conditions?
- yes no d/k Kidney problems?
- yes no d/k Diabetes?
- yes no d/k Cancer, tumor, radiation treatment or chemotherapy?
- yes no d/k Stomach ulcer or hyperacidity?
- yes no d/k Polio, mononucleosis, tuberculosis or pneumonia?
- yes no d/k Problems of the immune system?
- yes no d/k AIDS or HIV positive?
- yes no d/k Hepatitis, jaundice, or liver problems?
- yes no d/k Fainting spells, seizures, epilepsy or neurological problem?
- yes no d/k Mental health disturbance or behavioral problem?
- yes no d/k Vision, hearing, tasting or speech difficulties?
- yes no d/k Loss of weight recently, poor appetite?
- yes no d/k History of eating disorder (anorexia, bulimia)?
- yes no d/k Excessive Bleeding or bruising tendency, anemia or bleeding disorder?
- yes no d/k High or low blood pressure?
- yes no d/k Tires easily?
- yes no d/k Chest pain, shortness of breath or swelling ankles?
- yes no d/k Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?
- yes no d/k Skin disorder?
- yes no d/k Does the patient eat a well balanced diet?
- yes no d/k Frequent headaches, colds, or sore throats?
- yes no d/k Eye, ear, nose, or throat conditions?
- yes no d/k Hay fever, asthma, sinus trouble, or hives?
- yes no d/k Tonsil or adenoid conditions?

Allergies or reactions to any of the following?

- yes no d/k Local Anesthetics?
- yes no d/k Aspirin?
- yes no d/k Ibuprophen (Motrin, Advil)?
- yes no d/k Penicillin or other antibiotics?
- yes no d/k Sulfa drugs?
- yes no d/k Codeine or other narcotics?
- yes no d/k Metal (jewelry clothing snaps)?
- yes no d/k Latex (gloves, balloons)?
- yes no d/k Vinyl?
- yes no d/k Acrylic?
- yes no d/k Animals?
- yes no d/k Foods?
- Other Substances (specify) _____
- is the patient taking medication, nutrient supplements, herbal medications, or non prescription medicine?
- Please name them: _____
- _____
- _____
- yes no d/k Does the patient currently have or ever had a substance abuse problem?
- yes no d/k Does the patient chew or smoke tobacco?
- yes no d/k Operations? _____
- yes no d/k Hospitalized? _____
- yes no d/k Other physical problems or symptoms? _____
- _____
- yes no d/k Being treated by another health care professional? _____
- Are there any other medical conditions that we should be aware of? _____

Girls Only:

- yes no d/k Has the patient started her monthly periods?
- If so when? _____
- yes no d/k Is the patient pregnant?

Family Medical History:

- Do the patients parents or siblings have any of the following health problems? If so please explain.
- yes no d/k Bleeding disorders? _____
 - yes no d/k Diabetes? _____
 - yes no d/k Arthritis? _____
 - yes no d/k Metabolic disturbances? _____
 - yes no d/k Severe allergies? _____
 - yes no d/k Unusual dental problems? _____
 - yes no d/k Jaw size imbalance? _____
 - yes no d/k Any other family medical conditions we should know about? _____

Dental History:

Now or in the past has the patient had :

- yes no d/k Started teething very early or late?
- yes no d/k Primary (baby) teeth removed that were not loose?
- yes no d/k Permanent or "extra" (supernumerary) teeth removed?
- yes no d/k Supernumerary (extra) or congenitally missing teeth?
- yes no d/k Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no d/k Teeth sensitive to hot or cold; teeth throb or ache?
- yes no d/k Jaw fracture, cysts or mouth infections?
- yes no d/k "Dead teeth" or root canals treated?
- yes no d/k Bleeding gums, bad taste, or mouth odor?
- yes no d/k Periodontal (gum) problems?
- yes no d/k Food impaction between teeth?
- yes no d/k Thumb, finger, or sucking habit?
- yes no d/k Abnormal swallowing habit (tongue thrusting)?
- yes no d/k History of speech problems?
- yes no d/k Mouth breathing habit, snoring, or difficulty in breathing?
- yes no d/k Tooth grinding, jaw clenching clicking or locking?
- yes no d/k Any pain in jaw or ringing in the ears?
- yes no d/k Any pain or soreness in the muscles of the face or around the ears?

How often does your child brush? _____

Floss? _____

What is your primary concern? Why are you here?

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- yes no d/k Difficulty encountered in chewing or jaw opening?
 - yes no d/k Aware of loose, broken, or missing restorations (fillings)?
 - yes no d/k Any teeth irritating cheek, lip tongue or palate?
 - yes no d/k Concerned about spaced, crooked, or protruding teeth?
 - yes no d/k Aware of concerned about under or over developed jaw?
 - yes no d/k Frequent canker sores or cold sores?
 - yes no d/k Taking any form of fluoride?
 - yes no d/k Any relative with similar tooth or jaw relationship?
 - yes no d/k Had periodontal (gum) treatment?
 - yes no d/k Would patient object to wearing orthodontic appliances (braces) should they be indicated?
 - yes no d/k Any serious trouble associated with previous dental treatment?
 - yes no d/k Have you ever had prior orthodontic consultation or treatment?
 - yes no d/k If so When and where?
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I have read and understand the above questions. I will not hold my orthodontist or any member of his 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 inform this practice.

Signed: _____ Date: _____
(parent or guardian)

Signed: _____ Date: _____
(dental staff member)