



Date: _____

CONFIDENTIAL

**American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM FOR
PATIENTS UNDER 18 YEARS OF AGE**

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female I Prefer To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: _____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Attends School At: _____ Grade: _____

Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Birth Father's Height _____ ft. _____ in. Birth Mother's Height _____ ft. _____ in.

Patient's Birth Weight _____ lbs. _____ oz. Patient's Present Weight _____ lbs. Height _____ ft. _____ in.

Custodial Parent(s) or Guardian(s): _____

Phone No. (if different than patient's): _____

Address (if different than patient's): _____

City: _____ State/Province: _____ Zip/Postal Code: _____

E-mail address: _____ Cell phone/pager: _____

Name of Patient's Dentist: _____ Phone No.: _____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name of Patient's Physician(s): _____

Phone No(s): _____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Who Is Financially Responsible For This Account?

Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address (if different from patient's): _____

City: _____ State: _____ Zip: _____ Years at this address: _____

If less than five years, previous address: _____

City: _____ State: _____ Zip: _____

Phone No. (if different than patient's): _____ S.S.N./S.I.N.: _____

Employer: _____ How many years? _____

Insurance Coverage for Dental Treatment? Yes No Insurance Coverage for Orthodontic Treatment? Yes No

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No.: _____

Medical Insurance Company: _____ Group No.: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

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 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?

- yes no dk/u Does the patient eat a well-balanced diet?
- 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 adenoid conditions?

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 problem?
- 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?

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- 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, balloons)
- 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 currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers, such as Zometa (zoledronic acid), Aredia (pamidronate), Didronel (etidronate)?
- yes no dk/u Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

DENTAL HISTORY

- yes no dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does the patient chew or smoke tobacco?
- yes no dk/u Operations? Describe: _____
- _____
- yes no dk/u Hospitalized? Describe: _____
- _____
- 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? _____
- Are there any other medical conditions that we should be aware of?

GIRLS ONLY

- yes no dk/u Has the patient started her monthly periods?
If so, approximately when? _____
- yes no dk/u Is the patient pregnant?

FAMILY MEDICAL HISTORY

- Do the patient's parents or siblings have any of the following health problems?
If so, please explain.
- Bleeding disorders _____
- Diabetes _____
- Arthritis _____
- Metabolic disturbances _____
- Severe allergies _____
- Unusual dental problems _____
- Jaw size imbalance _____
- Any other family medical conditions that we should know about?

Now or in the past, has the patient had:

- yes no dk/u Started teething very early or late?
- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent or "extra" (supernumerary) 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 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 in jaw or 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 encountered in chewing or jaw opening?
- 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 "Gum boils", frequent canker sores or cold sores?
- yes no dk/u Taking any forms of fluoride?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u Had periodontal (gum) treatment?
- yes no dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?
- yes no dk/u Any serious trouble associated with any previous dental treatment?
- yes no dk/u Ever had a prior orthodontic examination or treatment?
- yes no dk/u Been under another dentist's care?
Specialist _____
Other _____

How often does your child 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 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 medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)