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MEDICAL AND DENTAL HISTORY FOR ORTHODONTIC TREATMENT

Please answer to the best of your knowledge and tick the appropriate box (elaborate if necessary). The history forms are office records and are considered **confidential**. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Name :_____ Date of Birth (D/M/Y) :_____

Medical History

Y □ N □ Birth defects/hereditary problems
Y □ N □ Fainting spells/seizures/epilepsy
Y □ N □ Rheumatoid/arthritic conditions
Y □ N □ Endocrine/diabetes/thyroid problems
Y □ N □ Kidney problems
Y □ N □ Skin disorders?
Y □ N □ Cancer/treated for a tumor?
Y □ N □ Hepatitis/jaundice/liver problem
Y □ N □ Stomach/bowel problems
Y □ N □ Bleeding disorders
Y □ N □ High/low blood pressure
Y □ N □ AIDS/HIV positive?
Y □ N □ Rheumatic fever/previous bacterial endocarditis?
Y □ N □ Heart problems _____
Y □ N □ History of speech problems
Y □ N □ Hay fever/asthma/sinus trouble?
Y □ N □ Tonsils/adenoid problems?_____
Y □ N □ Allergies/drug reactions? _____
Y □ N □ Currently taking medication? _____
Y □ N □ Previous surgery_____
Y □ N □ Recently hospitalized_____
Y □ N □ Current medical problems? _____

Female patients

Y □ N □ Are you pregnant?

Growth changes

Y □ N □ Has the patient reached puberty?
Y □ N □ Girls(menstruation) age_____
Y □ N □ Boys(voice change)age_____
Y □ N □ Knowledge of expected height?_____

Dental History

Y □ N □ Chipped/fractured permanent teeth
Y □ N □ Teeth sensitive to hot/cold
Y □ N □ Concern about under/over developed jaws
Y □ N □ Frequent dental visits?
Y □ N □ Root canal treatment
Y □ N □ Periodontal/gum problems (bleeding)
Y □ N □ Previous orthodontic treatment
Y □ N □ Thumb/finger sucking habit
Y □ N □ Abnormal swallowing habit/tongue thrusting
Y □ N □ Jaw clicking/pain
Y □ N □ Tooth grinding/jaw clenching
Y □ N □ Mouth breathing habit/snoring
Y □ N □ Missing teeth
Y □ N □ Supernumary (extra) teeth
Y □ N □ Spaced/crooked/protruding teeth?
Y □ N □ Parent/sibling with similar facial pattern?
Y □ N □ Wisdom teeth problems?
Y □ N □ Problems with previous dental treatment?
Y □ N □ Gag?
Y □ N □ Play musical instruments with lips/mouth?
Y □ N □ Contact sports?
Y □ N □ Current dental problems_____

Orthodontic wish list

_____
_____
_____

Additional Information

_____
_____
_____
_____

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene. Are there any restrictions, compromises, or problems that might be encountered during treatment?

_____

I have read and understood 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.

_____ _____
Signature of patient/parent Date