

Date: _____

Thank you for calling our office. Before we visit, please take time to consider and to answer the following questions. **Please give the completed form to our receptionist at your initial appointment.**

**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 Prefers To Be Called: _____

Home Phone No. _____

Patient's Address: _____

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

Attends School at: _____ Grade: _____ Musical Instrument Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____

Other family members treated here: _____

Father's Name: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Home Address (if different from patient's): _____

Cell Phone: _____

Mother's Name: _____

Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Home Address (if different from patient's): _____

Cell Phone: _____

Parental Status: Married Divorced Single Widowed

Person Responsible for this account: _____ Social Security #: _____

If this person is not the parent listed above, please fill out the following additional information:

Name: _____ Relation: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Business Phone: _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Name of the person who referred you to us:

Dentist: _____ City: _____

Other: _____ Address: _____

For the following questions mark yes, no or don't know/understand (dk/u).

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?

MEDICAL HISTORY

Now or in the past, has the patient 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 or 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 behavioral problem?
 yes no dk/u Vision, hearing, tasting or speech difficulties?
 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 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 defects, heart murmur or rheumatic heart disease)?
 yes no dk/u Skin disorder?
 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?

List any allergies or drug sensitivity

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 _____

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?

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. I understand that when appropriate, credit bureau reports may be obtained.

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

Signed: _____ Date Signed: _____
(Dental Staff Member)

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? _____

DENTAL HISTORY

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 Teeth sensitive to hot or cold; teeth throb or ache?
 yes no dk/u Jaw fracture, cysts or mouth infections?
 yes no dk/u Periodontal "gum problems"?
 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, jaw clenching clicking or locking?
 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 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 Any relative with similar tooth or jaw relationships?
 yes no dk/u Would patient 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 _____
 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? For: _____
 yes no dk/u Other physical problems or symptoms?
Describe: _____
Date of most recent physical exam? _____

Are there any other medical conditions that we should be aware of? _____