

**Patient's Dental/Medical History** (Please complete all questions. Write additional information if necessary.)

Please check the main concerns below:

- |  |                                    |   |  |  |   |
|--|------------------------------------|---|--|--|---|
| <input type="checkbox"/> Crowding        | <input type="checkbox"/> Overbite  | <input type="checkbox"/> Protrusion of teeth          | <input type="checkbox"/> Misalignment  | <input type="checkbox"/> Receding jaw    | <input type="checkbox"/> Prominent jaw        |
| <input type="checkbox"/> Gummy smile     | <input type="checkbox"/> Spacing   | <input type="checkbox"/> Gum disease/recession        | <input type="checkbox"/> Missing teeth | <input type="checkbox"/> Jaw dysfunction | <input type="checkbox"/> Mouth too small      |
| <input type="checkbox"/> Clicking in jaw | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irregular shaped teeth       | <input type="checkbox"/> Facial pain   | <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Jaw pain             |
| <input type="checkbox"/> Crossbite       | <input type="checkbox"/> Underbite | <input type="checkbox"/> Irregular facial proportions | <input type="checkbox"/> Openbite      | <input type="checkbox"/> Impacted teeth  | <input type="checkbox"/> Finger/thumb sucking |

List other family members with same dental problems? \_\_\_\_\_

Does the patient have pain/clicking in the jaw joints?     Yes     No    If yes, which side?  Right     Left     Both

Does the patient grind/clench teeth?     Yes     No     Unsure    Does the patient have difficulty chewing?     Yes     No

Injury to face or teeth?     Yes     No    If yes, please explain: \_\_\_\_\_

Has the patient been told they have a tongue thrust swallowing pattern?     Yes     No

Has the patient had a previous orthodontic exam/consultation?     No     Yes: when \_\_\_\_\_

Has the patient ever had orthodontic treatment?     Yes     No    Explain: \_\_\_\_\_

What is the patient's interest in orthodontic treatment?     Wants treatment     Willing if necessary     Unwilling but agrees     Unwilling

How is the patient's general health?     Excellent     Good     Fair     Poor

Has the patient reached puberty?     Yes     No    If yes, approximate date: \_\_\_\_\_

Does the patient smoke?     Yes     No

Is there anything in the patient's medical history that we should be aware of?     Yes     No

If yes, please explain: \_\_\_\_\_

Does the patient exhibit any developmental delays?  Yes     No    If yes, please explain: \_\_\_\_\_

List all medications the patient is currently taking: \_\_\_\_\_

Is the patient allergic to...?

- |                    |  |              |  |        |  |
|--------------------|--|--------------|--|--------|--|
| Dental Anesthetics | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tetracycline | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nickel | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Penicillin         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Aspirin      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Latex  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Erythromycin       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other:       | _____  |        |  |

Has the patient ever had or been treated for:

- |                      |  |                    |  |                      |  |
|----------------------|--|--------------------|--|----------------------|--|
| Heart problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood disorders      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart murmur         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sinus problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breathing difficulty | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fever blisters       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood transfusion    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe headaches     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tonsillitis          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Snoring            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsils Removed      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High blood pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Autoimmune disorder  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Adenoids removed     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleep disturbance    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eating disorder      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth-breathing    | <input type="checkbox"/> Yes <input type="checkbox"/> No |                      |  |

Other medical problems: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

***It is extremely important to inform our office of any changes in medical history.***