PFLUGERVILLE
ORTHODONTICS

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

Please check the main concerns below:

| | | | | | |
|---|---|---|---|---|---|
| □ Crowding | □ Overbite | □ Protrusion of teeth | □ Misalignment | □ Receding jaw | □ Prominent jaw |
| □ Gummy smile | □ Spacing | □ Gum disease/recession | □ Missing teeth | □ Jaw dysfunction | □ Mouth too small |
| □ Clicking in jaw | □ Headaches | □ Irregular shaped teeth | □ Facial pain | □ Neck pain | □ Jaw pain |
| □ Crossbite | □ Underbite | □ Irregular facial proportions | □ Openbite | □ Impacted teeth | □ 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 ever had orthodontic treatment? □ Yes □ No Explain: _____

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? □ 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: _____

Have you ever taken intravenous bisphosphonates for serious cancers, such as Zometa or Aredia? □ Yes □ No

Have you ever taken oral or intravenous bisphosphonates for osteoporosis, osteopenia, or other uses such as:
Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel, or Bonefos? □ No □ Currently taking □ Previously taken

Is the patient allergic to…?

Dental Anesthetics □ Yes □ No Nickel □ Yes □ No Latex □ Yes □ No

Other: _____

Has the patient ever had or been treated for:

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