American Association of Orthodontists

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 ☐ Prefers 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?

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** 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** 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?

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** 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 _____

☐**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: _____
☐**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?

_____

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** 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, 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** 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 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 _____

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: ________________
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