American Association of Orthodontists

CONFIDENTIAL

Date: ___/___/20____

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 birthweight _____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/Province: _____ Zip/Postal Code: _____

If less than five years, previous address: _____

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

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 you 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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