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DENTAL HISTORY

Frequency of dental checkup? _____ Date of last visit? _____

How many times per day does patient brush? _____

Does patient floss daily? No Yes

Does patient receive topical fluoride? No Yes

Is there any unfinished dental care to be completed? No Yes Explain _____

Is patient frightened about dental treatment? No Yes Explain _____

Has patient had an unpleasant experience in a dental office? No Yes Explain _____

Does patient play any musical instrument? No Yes What type? _____

Has patient consulted an orthodontist previously? No Yes With whom? _____

Has patient undergone any prior orthodontic treatment? No Yes By whom? _____

Were you satisfied with the prior treatment? No Yes Explain _____

Have any other family members had a similar dental pattern? No Yes Who? _____

Was it treated? No Yes By whom? _____

Has patient ever sustained any injury to mouth, teeth, jaws, neck or head? No Yes Explain _____

Has patient ever had muscular soreness around head/neck? No Yes

Problems with bleeding gums? No Yes

Oral surgery procedure? No Yes Periodontal (gum) treatment? No Yes

Prosthodontic (crown & bridge) treatment? No Yes Endodontic (root canal) treatment? No Yes

Does the patient have difficulty in swallowing/chewing food? No Yes Explain _____

Is the patient self-conscious about wearing braces? No Yes Explain _____

What are the patient's chief concerns regarding his/her teeth? _____

What are the parent's chief concerns about the patient's teeth? _____

What are the dentist's chief concerns about the patient's teeth? _____

Does the patient desire an improved dental appearance? No Yes

Does the patient clench/grind his/her teeth? No Yes When? _____

Does the patient have a nail biting habit? No Yes Lip biting habit? No Yes

Does the patient suck thumb or finger? No Yes If stopped, at what age? _____

Does the patient have a history of canker sores? No Yes

Has the patient ever had jaw joint pain? No Yes Jaw joint clicking? No Yes

Jaw joint locking? No Yes Jaw joint popping? No Yes Jaw joint grating noises? No Yes

Since diagnostic x-rays may be indicated, in the case of a female patient, is there presently a possibility of pregnancy?
 No Yes

I certify that the above medical history is accurate at this time. If there are future changes, I will inform the office. I also authorize this office to examine and initiate necessary dental services for this minor patient.

Signature _____ Date _____

Treatment Coordinator/Date _____

MEDICAL HISTORY

Your answers to the following questions will be helpful in setting the safest and most effective means of providing your child's orthodontic care. All information will be kept completely confidential.

Physician's Name _____ Phone _____

- Has the patient experienced any health problems? No Yes Explain _____
- Any major change in the patient's health recently? No Yes Explain _____
- Is the patient currently under physician's care? No Yes Explain _____
- Is the patient currently taking medications? No Yes List _____
- Is the patient allergic to any medications, metals, latex, plastics or other? No Yes List _____
- Has the patient ever been hospitalized? No Yes When? _____
- Have the patient's tonsils/adenoids been removed? No Yes When? _____
- Does the patient have any physical or mental impairment? No Yes Explain _____
- Has or is the patient currently undergoing speech therapy? No Yes Explain _____

Please check if patient has a history of any of the following conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Congenital Heart Disorder
<input type="checkbox"/> Endocrine Disorders
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Fainting Episodes
<input type="checkbox"/> Emotional Problems
<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Hemophilia
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Bone Disorder
<input type="checkbox"/> Development Disorder
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Herpes (Fever Blisters)
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Allergies
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Hepatitis (A)
<input type="checkbox"/> Hepatitis (B)
<input type="checkbox"/> Hepatitis (C)
<input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Mouth Breather
<input type="checkbox"/> Growth Disorders
<input type="checkbox"/> Cancer
<input type="checkbox"/> AIDS
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hives/Rash |
|---|--|--|

Are there any other conditions/problems of which we should be aware?

Comments: _____

MEDICAL HISTORY UPDATE:

Date	Comments	Signature

GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our selection of treatment alternatives:

- Has your son/daughter reached puberty? No Yes
- Females— Has she started menstruation? No Yes When? _____
- Males— Has his voice changed? No Yes When? _____ Has he begun to shave? No Yes When? _____
- Height _____ Do you feel growth is complete? No Yes Explain _____
- Is patient presently undergoing a rapid change in height? No Yes
- Father's height _____ Mother's height _____ Is child adopted? No Yes
- Names and birthdates of patient's siblings: _____