American Association of Orthodontics

MEDICAL DENTAL HISTORY FORM

Last Name: ______________________ First Name: ______________________ M.I.: ________

Birthdate: ______________________ Age: ______ Sex: Male __ Female __ I prefer to be called ______________

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.

MEDICAL HISTORY

Now or in the past, have you had:

___ yes ___ no ___ dk/u Birth defects or heredity 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 hyperactivity?
___ yes ___ no ___ dk/u Polio, mononucleosis, 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 problems?
___ yes ___ no ___ dk/u Fainting spells, seizures, epilepsy or neurological problems?
___ yes ___ no ___ dk/u Mental health disturbance or depression?
___ 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/Low blood pressure?
___ yes ___ no ___ dk/u Tired 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 Do you 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 condition or removal?
___ yes ___ no ___ dk/u Allergies? Specify ______________________
___ yes ___ no ___ dk/u Are you taking medication, nutritional supplements, herbal medications or non-prescription medicine? Please name them.

____

____

___ yes ___ no ___ dk/u Do you currently have or have you ever had a substance abuse problem?
___ yes ___ no ___ dk/u Do you chew or smoke tobacco?
___ yes ___ no ___ dk/u Operations?
Describe ______________________
___ yes ___ no ___ dk/u Hospitalized?
Describe ______________________
___ yes ___ no ___ dk/u Other physical problems or symptoms? ______________________

___ yes ___ no ___ dk/u Being treated by another health care professional?
For: ___
Date of most recent physical exam? ___
Are there any other medical conditions we should be aware of? ___
___

DENTAL HISTORY

Now or in the past, have you 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 or jaw clinching?
___ 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 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 of 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 you 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 do you 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/dentist status, I will so inform this practice.

Signed: ___ Date Signed: ___
(Patient or Parent)

Signed: ___ Date Signed: ___
(Orthodontist)