CONFIDENTIAL

Member
American Association of
Orthodontists

American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's Last Name_____First_____Middle_____
Birthdate_____Age_____Sex_____Home Phone No._____Cell _____
(Include area code & carrier)

Patient's Address – Street_____
City_____State_____Zip Code_____

Social Security No. Responsible Party_____Date Of Birth_____
His/Her Address_____City_____State_____Zip Code_____

E-Mail Address_____

Employer's Name & Address_____

Parent is Single___Married_____Widowed_____Separated_____Divorced___Parent/Guardian_____
Father's Height_____Mother's Height_____

Name of Patient's Dentist_____
Address_____Phone No._____

Name of Physician (s)_____
Address_____Phone No._____

No. of Brothers & Sisters_____Ages_____
Other Family Members Treated_____

Patient's Birth Weight_____Present Weight_____Height_____

Musical Instrument Played_____
Favorite Sports, Hobbies, & Avocations_____
Patient's School_____Grade_____

Insurance Yes_____ No_____ Subscriber's Date of Birth_____
Primary Insurance Co._____Policy No._____
Secondary Insurance Co._____Policy No._____

In Case We Cannot Reach You:
Person to Contact_____Phone No._____

For the following questions circle 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.

Yes no dk/u Does patient follow directions?
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, self-conscious?

MEDICAL HISTORY

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 or been treated for a tumor?
Yes no dk/u Stomach ulcer or hyperacidity?
Yes no dk/u Polio, mono, tuberculosis, 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 or behavioral problems?
Yes no dk/u Vision, hearing, tasting or speech difficulties?
Yes no dk/u Loss of weight recently, poor appetite?
Yes no dk/u Excessive bleeding, black and blue 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 or rheumatic heart?
Yes no dk/u Skin disorder?
Yes no dk/u Do you have a normal and good diet?
Yes no dk/u Frequent headaches, colds or sore throat?
Yes no dk/u Eye, ear, nose, throat conditions?
Yes no dk/u Hayfever, asthma, sinus trouble, hives?
Yes no dk/u Tonsil or adenoid conditions?
Yes no dk/u Allergies or drug reactions?
Allergic To:_____

Yes no dk/u Are you taking medications, nutrient supplements or non prescription medicine? Please name them.

Yes no dk/u Does the patient currently have or ever had a substance abuse problems?
Yes no dk/u Operations? (surgical procedures)?
Yes no dk/u Hospitalized for _____
Yes no dk/u Other physical problems or symptoms?
Yes no dk/u Being treated by another health care professional?
For_____
Date of most physical exam?_____

DENTAL HISTORY

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 dku Jaw fractures, cysts, mouth infections?
Yes no dk/u "Dead Teeth", root canals treated?
Yes no dk/u Bleeding gums, bad taste, mouth odor?
Yes no dk/u Periodontal "Gum Problems"?

Yes no dk/u "Gum Boils" frequent canker sores, cold sores?
Yes no dku Food Impaction between Teeth?
Yes no dk/u Is child taking any forms of fluoride?
Yes no dk/u Thumb, finger, sucking habit? Until_____
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, difficulty in breathing?
Yes no dk/u Tooth grinding, jaw clenching, clicking, locking?

Yes no dk/u Any pain in jaw or ringing in the ears?

Yes no dk/u Does the patient experience 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, palate?

Yes no dk/u Concerned about spaced, crooked, protruding tee
Yes no dk/u Aware or concerned about under or over develop jaw?
Yes no dk/u Any relative with similar tooth or jaw relationshi
Yes no dk/u Any wisdom teeth problems?

Yes no dk/u Has patient had any serious trouble associated w any previous dental treatment?
Yes no dk/u Onset of puberty (approximate date)?_____
Yes no dk/u Has patient ever had a prior orthodontic examination or treatment?
Yes no dk/u Has patient recently been under another dentist's care? Specialist_____
Other_____

Yes no dk/u Has patient ever had periodontal (gum) treatment
Yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
Yes no dk/u Date of most recent dental examination_____
How often does patient brush_____floss_____
What is the patient's (or parent's) primary concern?
Why are you here?

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for a errors or omissions that I have made in the completion of this fo If there are any changes later to this history record or medical/ dental status I will so inform this practice.

Signature of parent or guardian Date

Medical History Update or Changes: Date: Comments: Signatt