

# Dental History

Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Does the patient want orthodontic treatment?** \_\_\_\_\_

**What is your chief concern for today's visit?** \_\_\_\_\_

*Please circle the appropriate answer to the following questions, and explain if necessary.*

- Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Have you ever had speech therapy? If yes how long? \_\_\_\_\_
- Do you breathe mostly through the: nose \_\_\_\_\_ mouth \_\_\_\_\_ both \_\_\_\_\_ uncertain \_\_\_\_\_
- Yes No Have you ever had any abscessed teeth? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_
- Yes No Have you ever been informed of missing, extra or chipped teeth? \_\_\_\_\_
- Yes No Are you aware of clenching or grinding your teeth? \_\_\_\_\_
- Yes No Are you aware of jaw clicking or popping? \_\_\_\_\_
- Yes No Are your teeth or jaws ever uncomfortable when you awaken in the morning? \_\_\_\_\_
- Yes No Do you have any facial pain? \_\_\_\_\_
- Yes No Do you have any pain or soreness around your face, neck, or back? \_\_\_\_\_
- Yes No Do you have TMJ? \_\_\_\_\_
- Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_
- Yes No Do you have headaches? \_\_\_\_\_
- Yes No Have there ever been any injuries to the face, mouth or teeth? \_\_\_\_\_
- Yes No Do your gums bleed when you brush your teeth? \_\_\_\_\_
- Yes No Have you or anyone in your family had orthodontics? \_\_\_\_\_
- Yes No Does the patient resemble Mother and/or Father? \_\_\_\_\_
- Yes No Does anyone in the family have a similar dental condition? \_\_\_\_\_

## Medical Information

Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please circle Yes or No (If yes, please fill in the details.)**

- Yes No Are you taking any medications? \_\_\_\_\_
- Yes No Are you allergic to any medications? \_\_\_\_\_
- Yes No Are you presently under care of a physician? \_\_\_\_\_
- Yes No Do you have history of a major illness? \_\_\_\_\_
- Yes No Have you ever had any major operations? \_\_\_\_\_
- Yes No Have you ever been hospitalized? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Have you had your tonsils or adenoids removed? \_\_\_\_\_
- Yes No Have you ever had any of the following: Asthma \_\_\_\_\_ Allergies \_\_\_\_\_ Hayfever \_\_\_\_\_ Throat infections \_\_\_\_\_

What are you allergic to? \_\_\_\_\_

**Please circle the appropriate answer for the medical conditions below:**

- |   |  |                                |
|---|--|--------------------------------|
| Yes No Abnormal bleed                             | Yes No Endocrine Problems                        | Yes No Liver Disease           |
| Yes No Tuberculosis                               | Yes No Anemia                                    | Yes No Epilepsy                |
| Yes No Lung/Respiratory Disease                   | Yes No Aids                                      | Yes No Arthritis               |
| Yes No Glaucoma                                   | Yes No HIV+                                      | Yes No Blood Disorders         |
| Yes No Heart Murmur                               | Yes No Nervous Disorders                         | Yes No Contact Lenses          |
| Yes No Prolonged Bleeding                         | Yes No Heart Problems                            | Yes No Pneumonia               |
| Yes No Other _____                                | Yes No Hepatitis - Type _____                    | Yes No High Blood Pressure     |
| Yes No Rheumatic Fever                            | If a child have you reached puberty?..... Yes No |                                |
| Yes No Bone/Joint Disorder                        | Yes No Hyperactive                               | Yes No Rheumatic Heart Disease |
| Yes No Cancer or Tumor                            | Yes No Dizziness/Fainting                        | Yes No Diabetes                |
| Girls, have you started menstruation?..... Yes No | Yes No Thyroid Disease                           | Yes No Emotional Problems      |
| Yes No Herpes                                     | Yes No Sinusitis                                 |                                |
| Yes No Kidney Involvement                         | Yes No   |                                |
| Boys, has your voice changed?..... Yes No         |  |                                |

### Benefits of Orthodontics; Aesthetics, Health and Function

Orthodontics is a service that provides an improvement in the appearance of the teeth, the general function of the teeth, and in general dental health. Teeth, gums and jaw are an intricate body part, and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime, and there can be some movement of the teeth, and some change after treatment. I hereby state that I have read and understand the above paragraph, and that I have truthfully to the best of my ability answered all of the above questions.

Patient/Parent Signature \_\_\_\_\_ Date \_\_\_\_\_