



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

Date: _____

CONFIDENTIAL

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female I Prefer 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 Birth Weight _____ 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: _____ Zip: _____ Years at this address: _____

If less than five years, previous address: _____

City: _____ State: _____ Zip: _____

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 your child 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?

- 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?

MEDICAL HISTORY

Now or in the past, have you 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, 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 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 or 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)?

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? Describe: _____
 - 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 or jaw clenching?
- 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 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 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)