Medical Dental History Form for Patients Under Age 18

Date _____

Patient's Last Name _____ Patient's First Name _____

Birth Date _____

Dentist Name _____ Dentist Phone Number _____

What concerns you about your child's teeth?

Who suggest that you might need orthodontic treatment?

Parents/Guardian

Custodial Parent Name _____ Patient lives with _____

Father's Full Name _____ Father's Phone Number _____

Mother's Full Name _____ Mother's Phone Number _____

Medical History

Birth Defect or Hereditary Problem? No

Any injuries to face, head, neck? No

Arthritis or joint problem? No

Endocrine or thyroid Problems? No

Diabetes or low sugar? No

Kidney Problem? No

Cancer, tumor, radiation treatment or chemotherapy? No

Stomach ulcer, hyperacidity, acid reflux? No

Immune system problem? No

History of osteoporosis? No

Gonorrhea, syphilis, herpes, sexually transmitted diseases? No

AIDS or HIV positive? No

Hepatitis, jaundice, or other liver problem? No

Polio, mononucleosis, tuberculosis, pneumonia? No

Seizures, Fainting spells, neurologic problems? No

Mental health disturbance or depression? No

Visio, hearing or speech problems? No

History of eating disorder? No

High or low blood pressure? No

Excessive bleeding or bruising, anemia? No

Chest pain, shortness of breath, tire easily, swollen ankles? No

Heart defects, heart murmur, rheumatic heart disease? No

Angina, arteriosclerosis, stroke, or heart attack? No

Skin disorder? No

Do you eat a well-balanced diet? No

Frequent headaches or migraines? No

Frequent ear infections, colds, throat infections? No

Asthma, sinus problems, hayfever? No

Tonsil or adenoid condition? No

Do you frequently breathe through mouth? No

Do you snore? No

Has your snoring ever bothered anyone? No

Has anyone noticed that you stop breathing during your sleep? No

Do you feel fatigued or tired after your sleep? No

During your waking time, do you feel tired, or fatigued? No

Have you ever fallen asleep while driving a vehicle? No

Have you had allergies or reactions to any of the following?

Local anesthetics (novocaine, lidocaine, xylocaine) No

Latex (gloves, balloons) No

Aspirin No

Metals (jewelry, clothing snaps) No

Penicillin No

Other antibiotics No

Ibuprofen (Motrin, Advil), Acrylics No

Plant pollens No

Animals No

Foods No

Other substances _____

Dental History

Permanent or extra (supernumerary) teeth removed? No

Supernumerary (extra) or congenitally missing teeth? No

Chipped or injured primary or permanent teeth? No

Any sensitive or sore teeth? No

Bleeding gums, bad taste or mouth odor? No

Jaw fractures, cysts, infections? No

Any teeth, treated with root canals or pulpotomies? No

Gum boils, frequent cancer sores or cold sores? No

History of speech problems or speech therapy? No

Difficulty breathing through nose? No

Food impaction between the teeth? No

Mouth breathing habit or snoring at night? No

Frequent oral habits (sucking finger, chewing pen)? No

Teeth causing irritation to lip, cheek or gums? No

Abnormal swallowing (tongue thrust)? No

Tooth grinding or clenching? No

Clicking, locking in jaw joints? No

Soreness in jaw muscles or face muscles? No

Ringing in ears, difficulty in chewing or opening jaw? No

Have you ever been treated for TMJ or TMD problems? No

Any broken or missing fillings? No

Any serious trouble associated with previous dental treatment? No

Have you ever been diagnosed with gum disease? No

Have you ever had an orthodontic consultation or treatment before now? No

List of any Medications

_____

_____

Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental or medical insurance company.

Signature: _____

Date: _____

Medical History Updated or Changes

Changes: _____

_____

Signature: _____

Date: _____

Dental Staff Signature: _____

Date: _____