Your answers are for office records only and are confidential. A thorough medical history is essential to complete an orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand (dk/u).

If you mark "YES, please explain.

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/major injuries?
☐Yes ☐No ☐dk/u Injuries to head, face, neck?
☐Yes ☐No ☐dk/u Arthritis or joint problems?
☐Yes ☐No ☐dk/u Cancer, tumor, radiation or chemotherapy?
☐Yes ☐No ☐dk/u Endocrine or thyroid problems?
☐Yes ☐No ☐dk/u Diabetes or low sugar?
☐Yes ☐No ☐dk/u Kidney problems?
☐Yes ☐No ☐dk/u Immune system problems?
☐Yes ☐No ☐dk/u History of osteoporosis?

☐Yes ☐No ☐dk/u Hepatitis, jaundice, or other liver problems?
☐Yes ☐No ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐Yes ☐No ☐dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases'?
☐Yes ☐No ☐dk/u AIDS or HIV positive?
☐Yes ☐No ☐dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐Yes ☐No ☐dk/u Mental health disturbance or depression?
☐Yes ☐No ☐dk/u History of eating disorder (anorexia, bulimia)?

☐Yes ☐No ☐dk/u High or low blood pressure? (Circle one)
☐Yes ☐No ☐dk/u Excessive bleeding/bruising tendency, anemia?
☐Yes ☐No ☐dk/u Vision, hearing, or speech problems?
☐Yes ☐No ☐dk/u Heart defects, heart murmur, rheumatic heart disease?
☐Yes ☐No ☐dk/u Angina, arteriosclerosis, stroke or heart attack?
☐Yes ☐No ☐dk/u Skin disorder (other than common acne)?
☐Yes ☐No ☐dk/u Do you eat a well balanced diet?
☐Yes ☐No ☐dk/u Frequent headaches or migraines?
☐Yes ☐No ☐dk/u Frequent ear infections, colds, throat problems?
☐Yes ☐No ☐dk/u Asthma, sinus problems, hay fever?
☐Yes ☐No ☐dk/u Tonsils or adenoid condition?
☐Yes ☐No ☐dk/u Do you frequently breathe through your mouth?
☐Yes ☐No ☐dk/u Stomach ulcer, hyperacidity, acid reflux?

Other____

____

ALLERGIES

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

☐Yes ☐No ☐dk/u Local anesthetics (Novocain, Lidocaine)
☐Yes ☐No ☐dk/u Latex (Gloves, balloons)
☐Yes ☐No ☐dk/u Aspirin
☐Yes ☐No ☐dk/u Ibuprofen (Motrin, Advil)
☐Yes ☐No ☐dk/u Penicillin
☐Yes ☐No ☐dk/u Other antibiotics
☐Yes ☐No ☐dk/u Metals (jewelry, clothing)
☐Yes ☐No ☐dk/u Acrylics
☐Yes ☐No ☐dk/u Plant pollens
☐Yes ☐No ☐dk/u Animals
☐Yes ☐No ☐dk/u Food ______________________
☐Yes ☐No ☐dk/u Other substances

____

DENTAL HISTORY

Now or in the past, have you had:

☐Yes ☐No ☐dk/u Had an orthodontic consultation before?
☐Yes ☐No ☐dk/u Permanent/extra teeth removed?
☐Yes ☐No ☐dk/u Extra or missing permanent/adult teeth?
☐Yes ☐No ☐dk/u Chipped or injured primary/permanent teeth?

☐Yes ☐No ☐dk/u Any sensitive or sore teeth?
☐Yes ☐No ☐dk/u Bleeding gums, bad taste or mouth odor?
☐Yes ☐No ☐dk/u Jaw fractures, cysts, infections?
☐Yes ☐No ☐dk/u Any lost or broken fillings?
☐Yes ☐No ☐dk/u Frequent canker sores or cold sores?
☐Yes ☐No ☐dk/u History of speech problems or speech therapy?
☐Yes ☐No ☐dk/u Difficulty breathing through nose?
☐Yes ☐No ☐dk/u Do you snore at night?
☐Yes ☐No ☐dk/u Food impaction between teeth?
☐Yes ☐No ☐dk/u Frequent oral habits?
☐Yes ☐No ☐dk/u Teeth causing irritation to lip, cheek or gums?
☐Yes ☐No ☐dk/u Tooth grinding or clenching?
☐Yes ☐No ☐dk/u Clicking, locking in jaw joints?
☐Yes ☐No ☐dk/u Soreness in jaw or face muscles?
☐Yes ☐No ☐dk/u Ringing in ears?
☐Yes ☐No ☐dk/u Difficulty in chewing or opening jaw?
☐Yes ☐No ☐dk/u Any serious trouble with previous dental treatment?
☐Yes ☐No ☐dk/u Ever been diagnosed with gum disease?

ADDITIONAL HISTORY:

Now or in the past, have you had:

☐Yes ☐No ☐dk/u MRSA?
☐Yes ☐No ☐dk/u Have you ever taken intravenous bisposphonates such as Zometa, Aredia, or Didronel for bone disorders or cancer?
☐Yes ☐No ☐dk/u Have you ever taken oral bisphosphonates such as Fosomax, Actonel, Boniva, Skelid, or Didronel for bone disorders?

PATIENT HEALTH INFORMATION

List any medications, nutritional supplements, herbal medications or non-prescription medicines, including fluoride, supplements that you take.

Medication ____ Taken for________________________________
Medication ____ Taken for________________________________
Medication ____ Taken for________________________________

Have you ever taken any medication to strengthen your bones? Please describe_______________________

Do you or have you ever had a substance abuse problem? ____
Do you chew or smoke tobacco? _______________________________
Have you noticed any changes in your face or jaws? ______________________________
Any other physical problems? ____
How often do you brush? ______________________
How often do you floss? ________________________
Women: Are you pregnant? _______ Yes _______ No Are you trying to become pregnant? _____ Yes ______ No

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Sleep Apnea/ CPAP/ Snoring _____________________________________
Bleeding disorders ____
Diabetes____
Arthritis____
Severe allergies____
Unusual dental problems______________________________________
Jaw size imbalance ____
Other family medical conditions ________________________________

RELEASE AND WAIVER

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

Signature ____ Date: ____________________________

I have read the above questions and understand them. I will not hold my orthodontist or any of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____ Date: ____________________________

MEDICAL HISTORY UPDATES OR CHANGES

Changes ____ Yes ____ No
Patient signature ____ Date ______________________________
Dental Staff Signature ____ Date ______________________________

Changes ____ Yes ____ No
Patient signature ____ Date ______________________________
Dental Staff Signature ____ Date ______________________________

Changes ____ Yes ____ No
Patient signature ____ Date ______________________________
Dental Staff Signature ____ Date ______________________________

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