HUDSON
ORTHODONTICS FOR ALL AGES

CONFIDENTIAL **DATE_____**

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

Patient's Last Name:_____ First Name:_____ Initial:____

Birth Date:____/____/_____ Age:_____ Biological Sex: Male_____ Female_____

***What Concerns YOU About Your Child's Teeth?*_____**

***What Concerns YOUR CHILD About His/Her Teeth?*_____**

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 current height____ft._____in.____

Custodial Parent(s) or Guardian(s):_____

Ph. #(if different than patient)_____-_____

Address (if different than patient):_____

City:_____ State:_____Zip:_____

Name of Patient's DENTIST:_____Phone No.:_____

Dentist's Address:_____

City:_____State:_____Zip:_____

Date Last Seen:_____ Reason:_____

Name of Patient's PHYSICIAN(s):_____Phone No:_____

Physician's Address:_____

City:_____State:_____Zip:_____

Date Last Seen:_____Reason_____

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 the box "Yes" for something with more than one condition, please circle the one that applies or write in the margins or at the bottom of this page. Thanks!

If you mark "YES", please explain.

MEDICAL HISTORY

Now or in the past, has your child had:

☐Yes ☐No ☐dk/u Birth defects or heredity problems? _____
☐Yes ☐No ☐dk/u Bone fractures/major injuries? _____
☐Yes ☐No ☐dk/u Injuries to face, head, or neck?
☐Yes ☐No ☐dk/u Arthritis or joint problems?
☐Yes ☐No ☐dk/u Cancer, Tumor, radiation treatment or chemo?
☐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 AIDS, Sexually transmitted diseases or HIV positives?
☐Yes ☐No ☐dk/u Chest pain, shortness of breath, tired easily, swollen ankles?
☐Yes ☐No ☐dk/u Mental health disturbance?
☐Yes ☐No ☐dk/u History of eating disorder (anorexia or bulimia)?
☐Yes ☐No ☐dk/u Frequent headaches or migraine?
☐Yes ☐No ☐dk/u High or low blood pressure?
☐Yes ☐No ☐dk/u Excessive bleeding pr bruising tendency, anemia?
☐Yes ☐No ☐dk/u Seizures, fainting spells, neurologic problem?
☐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 Does your child eat a well-balanced diet?
☐Yes ☐No ☐dk/u Vision, hearing or speech problems?
☐Yes ☐No ☐dk/u Frequent ear infections, colds, throat infections?
☐Yes ☐No ☐dk/u Asthma, sinus problems, hay fever?
☐Yes ☐No ☐dk/u Tonsil or adenoid condition?
☐Yes ☐No ☐dk/u Frequently breathe through his/her mouth?
☐Yes ☐No ☐dk/u Has your child ever taken intravenous bisphosphonates such as: Zometa (zolendromic acid) Aredia (pamidronate) or Didronel (etidronate) for Bone disorder or cancer?
☐Yes ☐No ☐dk/u Has your child ever taken oral bisphosponates such a Fosomax (alendronate), Actonel (ridendronate),,Boniva (ibandronate), Skelid (tiludronate) or Dridonel (etidronate) for bone disorder?
☐Yes ☐No ☐dk/u Spectrum disorder (Autism, Asperger's…)
☐Yes ☐No ☐dk/u Hyperactivity disorder (ADD, ADHD)
☐Yes ☐No ☐dk/u Acid reflux, GERD

Other/Explain
_____

_____

ALLERGIES

Has your child had allergies or reactions to any of the following?

☐Yes ☐No ☐dk/u Local anesthetics (novacaine, lidocaine, xylocaine)
☐Yes ☐No ☐dk/u Latex (gloves or 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, nickel)
☐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, has the patient had:

☐Yes ☐No ☐dk/u Erupting teeth very early or very late?
☐Yes ☐No ☐dk/u Primary (baby) teeth removed that were not loose
☐Yes ☐No ☐dk/u Permanent/extra teeth (supernumerary) removed?
☐Yes ☐No ☐dk/u Extra or missing permanent /adult teeth?
☐Yes ☐No ☐dk/u Chipped or injured primary or permanent teeth?
☐Yes ☐No ☐dk/u Any sensitive or sore teeth?
☐Yes ☐No ☐dk/u Jaw fractures, cysts, infections?
☐Yes ☐No ☐dk/u Any teeth treated with root canals or pulpotomies?
☐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 Mouth breathing habit or snoring at night?
☐Yes ☐No ☐dk/u Frequent oral habits (sucking finger, chewing)
☐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 muscles or face muscles?
☐Yes ☐No ☐dk/u Has your child been treated for "TMJ" or "TMD" problems?
☐Yes ☐No ☐dk/u Any serious trouble associated with previous dental Treatment?
☐Yes ☐No ☐dk/u Has your child ever been diagnosed w/ gum disease
☐Yes ☐No ☐dk/u Have you ever has an orthodontic consultation?

_____

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?

PATIENT HEALTH INFORMATION:

Do you think that any of your child's activities affect his/her face, teeth, or jaw? If yes, how?
_____

List any medication, nutritional supplements, herbal medications or non-prescription medicine, including fluoride supplement that your child takes.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

Does the patient currently have (or ever had) a substance abuse problem?
_____

Does your child chew, vape or smoke tobacco? _____
Have you noticed any unusual changes in your child's face or jaws? _____
_____
Any other physical problems? _____
_____

FAMILY MEDICAL HISTORY:

Have the 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_____
_____

How often does your child brush? _____
Floss? _____

RELEASE AND WAIVER:

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

Parents/Guardian Signature_____Date_____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my child's medical or dental health.

Parents/Guardian Signature_____Date_____

MEDICAL HISTORY UPDATES

Any changes made? Yes NO
Parents/Guardian Signature_____Date_____
Dental staff signature_____Date_____

Any changes made? Yes NO
Parents/Guardian Signature_____Date_____
Dental staff signature_____Date_____

Any changes made? Yes NO
Parents/Guardian Signature_____Date_____
Dental staff signature_____Date_____