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/Genetic 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_____

CONFIDENTIAL

A thorough medical history is essential to an orthodontic evaluation. For the following questions, please mark yes, no, or don't know (dk). If there is more than one option, please circle the correct one or write in at the bottom.

If you mark "YES, please explain.

MEDICAL HISTORYALLERGIES

Now or in the past, has your child had: Has your child had allergies/reactions to any of the following:

□Yes □No □dkBirth defects or heredity issues: _____□Yes □No □dk/u Novacaine, Lidocaine, Xylocaine

□Yes □No □dkBone fractures/major injuries: (Explain Below)□Yes □No □dk/u Latex (gloves or balloons)

□Yes □No □dkInjuries to face, head, or neck: (Explain Below)□Yes □No □dk/u Aspirin

□Yes □No □dkArthritis or joint problems: (Explain Below)□Yes □No □dk/u Ibuprofen (Motrin, Advil)

□Yes □No □dkCancer, Tumor, radiation, chemo: (Explain Below)□Yes □No □dk/u Penicillin, Amoxicillin

□Yes □No □dk Endocrine or thyroid problems: (Explain Below)□Yes □No □dk/u Other antibiotics_____

□Yes □No □dk Diabetes or low sugar:□Yes □No □dk/u Metals (jewelry, clothing, nickel) (Explain Below)

□Yes □No □dk Kidney problems: (Explain Below)□Yes □No □dk/u Acrylics

□Yes □No □dk Immune system problems: (Explain Below)□Yes □No □dk/u Plant pollens

□Yes □No □dk History of osteoporosis:(Explain Below)□Yes □No □dk/u Animals

□Yes □No □dkTonsil or adenoid conditions: _____□Yes □No □dk/u Food _____

□Yes □No □dk Hepatitis, jaundice, liver problems: (Explain Below)□Yes □No □dk/u Other Substances_____

□Yes □No □dk Polio, mononucleosis, tuberculosis, pneumonias: (Explain Below)

□Yes □No □dkAIDS, Sexually transmitted diseases or HIV positives: _____

□Yes □No □dkChest pain, shortness of breath, tired easily, swollen ankles:

□Yes □No □dkMental health issues:_____**DENTAL HISTORY:**

□Yes □No □dkHistory of eating disorder (anorexia or bulimia): Now or in the past, has the patient had:

□Yes □No □dkFrequent headaches or migraines:□Yes □No □dk/u Frequent canker sores or cold sores:

□Yes □No □dkHigh or low blood pressure: (circle one)□Yes □No □dk/u Erupting teeth very early or very late:

□Yes □No □dkExcessive bleeding pr bruising tendency, anemias:□Yes □No □dk/u Primary (baby) teeth removed that were not loose:

□Yes □No □dkSeizures, fainting spells, neurologic problems:□Yes □No □dk/u Permanent/extra teeth (supernumerary) removed:

□Yes □No □dkHeart defects, heart murmur, rheumatic heart disease:□Yes □No □dk/u Extra or missing permanent/adult teeth:

□Yes □No □dkAngina, arteriosclerosis, stroke, or heart attack:□Yes □No □dk/u Chipped or injured primary or permanent teeth:

□Yes □No □dkSkin disorder (other than common acne):_____□Yes □No □dk/u Any sensitive or sore teeth:

□Yes □No □dkDoes your child eat a well-balanced diet:□Yes □No □dk/u Jaw fractures, cysts, infections: (Explain Below)

□Yes □No □dkVision or hearing problems: (Explain Below)□Yes □No □dk/u Any teeth treated with root canals or pulpotomies:

□Yes □No □dkFrequent ear infections, colds, throat infections:□Yes □No □dk/u Diagnosed w/gum disease:

□Yes □No □dkAsthma, sinus problems, hay fever:□Yes □No □dk/u Speech problems or speech therapy:

□Yes □No □dkAcid reflux, GERD □Yes □No □dk/u Difficulty breathing through nose:

□Yes □No □dkFrequently breathe through his/her mouth:□Yes □No □dk/u Mouth breathing habit or snoring at night:

□Yes □No □dkHas your child ever taken intravenous□Yes □No □dk/u Oral habits (sucking finger, chewing)_____

bisphosphonates such as: Zometa (zolendromic acid) □Yes □No □dk/u Teeth causing irritation to lip, cheek or gums:

Aredia (pamidronate) or Didronel (etidronate)□Yes □No □dk/u Tooth grinding or clenching:

for Bone disorder or cancer:□Yes □No □dk/u Clicking/locking in jaw joints:

□Yes □No □dkHas your child ever taken oral bisphosponates□Yes □No □dk/u Soreness in jaw muscles or face muscles:

such a Fosomax (alendronate), Actonel □Yes □No □dk/u Has your child been treated for "TMJ"/"TMD"

(ridendronate), Boniva (ibandronate), problems?

Skelid (tiludronate) or Dridonel (etidronate) □Yes □No □dk/u Any serious trouble with dental treatments

for bone disorders? □Yes □No □dk/u Have you ever has an orthodontic consultations?

□Yes □No □dk Spectrum disorder (Autism, Asperger's...)? _____

□Yes □No □dk Hyperactivity disorder (ADD, ADHD)? _____

Other/Explain

_____

_____

_____

_____

_____

_____

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GIRLS ONLY:

□Yes □No □dk Has the patient started her monthly periods? If so, approximately when?

_____

□Yes □No □dk Is the patient pregnant? Due date _____/_____/_____

PATIENT HEALTH INFORMATION:

Do you have a condition that requires antibiotics before dental procedures? _____

Do you think that any of your child's activities affect his/her face, teeth, or jaws? 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?

_____

_____
_____

How often does your child brush?

_____

Floss?

_____
_____

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_____
- _____

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_____