HUDSON
ORTHODONTICS FOR ALL AGES

MEDICAL DENTAL HISTORY FORM FOR PATIENTS UNDER 18 YEARS OF AGE

DATE _____/_____/_____

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

Birth Date:____/____/_____ **Age:**_____ **Biological/Genetic Sex: Male**_____ **Female**_____

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

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

Address (if different than patient):_____

City:_____ **State:**_____**Zip:**_____

What Concerns YOU About Your Child's Teeth?_____

What Concerns YOUR CHILD About His/Her Teeth?_____

Attends School At:_____**Grade:**_____ **Musical Instruments:**_____

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.**

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

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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 HISTORY

Now or in the past, has your child had:

▫Yes ▫No ▫dk Birth defects or heredity issues? _____
▫Yes ▫No ▫dk Bone fractures/major injuries? (Explain Below)
▫Yes ▫No ▫dk Injuries to face, head, or neck? (Explain Below)
▫Yes ▫No ▫dk Arthritis or joint problems? (Explain Below)
▫Yes ▫No ▫dk Cancer, Tumor, radiation, chemo? (Explain Below)
▫Yes ▫No ▫dk Endocrine or thyroid problems? (Explain Below)
▫Yes ▫No ▫dk Diabetes or low sugar?
▫Yes ▫No ▫dk Kidney problems? (Explain Below)
▫Yes ▫No ▫dk Immune system problems? (Explain Below)
▫Yes ▫No ▫dk History of osteoporosis? (Explain Below)
▫Yes ▫No ▫dk Tonsil or adenoid condition? _____
▫Yes ▫No ▫dk Hepatitis, jaundice, liver problems? (Explain Below)
▫Yes ▫No ▫dk Polio, mononucleosis, tuberculosis, pneumonia? (Explain Below)
▫Yes ▫No ▫dk AIDS, Sexually transmitted diseases or HIV positives? _____
▫Yes ▫No ▫dk Chest pain, shortness of breath, tired easily, swollen ankles?
▫Yes ▫No ▫dk Mental health issues?_____
▫Yes ▫No ▫dk History of eating disorder (anorexia or bulimia)?
▫Yes ▫No ▫dk Frequent headaches or migraine?
▫Yes ▫No ▫dk High or low blood pressure? (circle one)
▫Yes ▫No ▫dk Excessive bleeding pr bruising tendency, anemia?
▫Yes ▫No ▫dk Seizures, fainting spells, neurologic problem?
▫Yes ▫No ▫dk Heart defects, heart murmur, rheumatic heart disease?
▫Yes ▫No ▫dk Angina, arteriosclerosis, stroke, or heart attack?
▫Yes ▫No ▫dk Skin disorder (other than common acne)?_____
▫Yes ▫No ▫dk Does your child eat a well-balanced diet?
▫Yes ▫No ▫dk Vision or hearing problems? (Explain Below)
▫Yes ▫No ▫dk Frequent ear infections, colds, throat infections?
▫Yes ▫No ▫dk Asthma, sinus problems, hay fever?
▫Yes ▫No ▫dk Acid reflux, GERD
▫Yes ▫No ▫dk Frequently breathe through his/her mouth?
▫Yes ▫No ▫dk 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 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 Spectrum disorder (Autism, Asperger's…)? _____
▫Yes ▫No ▫dk Hyperactivity disorder (ADD, ADHD)? _____

ALLERGIES

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

▫Yes ▫No ▫dk/u 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, Amoxicillin
▫Yes ▫No ▫dk/u Other antibiotics_____
▫Yes ▫No ▫dk/u Metals (jewelry, clothing, nickel) (Explain Below)
▫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 Frequent canker sores or cold sores?
▫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? (Explain Below)
▫Yes ▫No ▫dk/u Any teeth treated with root canals or pulpotomies?
▫Yes ▫No ▫dk/u Diagnosed w/ gum disease?
▫Yes ▫No ▫dk/u 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 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"/"TMD" problems?
▫Yes ▫No ▫dk/u Any serious trouble with dental treatment?
▫Yes ▫No ▫dk/u Have you ever has an orthodontic consultation?

Other/Explain _____

_____

_____

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 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 and/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 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_____

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