

Dental & Health History

Family Dentist: _____ Date of Last Check-Up: _____

Family Physician: _____

Whom may we thank for referring you to this office? _____

Has the patient been seen previously by an orthodontist? _____

Is the patient under treatment by a physician or taking any medication? _____

For?: _____ Pharmacy: _____ Phone Number: _____

Would the patient mind wearing braces if necessary? _____

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|--------------------------|--------------------------|--------------------------|--|
| | Yes | No | (IF YES, CIRCLE THE APPROPRIATE ANSWER) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Major Falls, Injuries, or Operations Involving the Head or Teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever, Diabetes, Asthma, Convulsions, Fainting, Anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mouth Sores, Herpes (Cold Sores), AIDS, Infectious Hepatitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Repeated Headaches, Sore Throats, Colds, Ear Infections? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the patient require pre-medication for any type of medical condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other Illness or Surgery: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies to: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Speech Problems: _____ |

Health History Reviewed & Updated Date: _____

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|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| | Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any difficulty swallowing or chewing food? | <input type="checkbox"/> | <input type="checkbox"/> | Any muscular twitches relating to teeth _____ or face _____? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any special eating problem or digestive disturbance? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Pain on opening _____ or closing _____ of mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does the patient vomit, gag, or faint easily? | <input type="checkbox"/> | <input type="checkbox"/> | Clicking on opening _____ or closing _____ of mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any difficulty breathing through the nose? | <input type="checkbox"/> | <input type="checkbox"/> | Facial pain _____ or jaw pain _____? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Is the patient a mouth breather? While awake? _____ While asleep? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Teeth clenching _____ or grinding _____ at night? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thumb _____ or Finger _____ sucking? To what age? _____ | <input type="checkbox"/> | <input type="checkbox"/> | Repeated headaches due to mouth _____, teeth _____, or jaw _____ problems? |

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|-----|----|---|
| Yes | No | Do gums bleed when brushing? |
| Yes | No | History of Periodontal Problems? If yes, Last Perio Check-Up _____ With who? _____ |
| Yes | No | Repeated sore throats or tonsillitis? |
| Yes | No | Any other problems relating to tonsils and/or adenoids? |
| Yes | No | Have they been removed? Tonsils and/or adenoids? Year _____ |
| Yes | No | Baby or permanent teeth removed by the dentist? |
| Yes | No | Has patient reached puberty? Girl- Menstruation _____ Boy-Voice Change _____ |
| Yes | No | Is patient sensitive or concerned about the appearance of his/her teeth? |
| Yes | No | Anyone else in the family have a similar dental condition, bite, or arrangement of teeth? _____ |
| Yes | No | Has either patient or other children had orthodontic treatment? |
| Yes | No | Does patient play a musical instrument? If yes, what? _____ |
| Yes | No | Are you satisfied with patient's present height and weight? |