

DAVID ORTHODONTICS

CONFIDENTIAL

DATE: _____

MEDICAL DENTAL HISTORY FORM - PATIENTS UNDER 18 YEARS OF AGE

Patient's Last Name: _____ Legal First Name: _____

Birth date: (dd-mm-yy) _____ Preferred Name: _____

Mailing Address: _____ Responsible Party Name: _____

_____ Address: Same as Patient? Yes -

Home Phone: _____ Business Phone: _____

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

Siblings in our practice: _____

Whom may we thank for referring you to our clinic? _____

If you would like to receive automatic appointment reminders from our office, please provide your: e-mail address (print clearly) _____ Cell phone: _____

DENTAL INFORMATION

Dentist's Name: _____ Date of last check up: _____

For the following questions mark **yes, no or don't know (d/k)**.

	yes	no	d/k
1. Has any family member had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you dissatisfied with the function of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you been informed of missing teeth or teeth that did not form?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you experienced a clicking of the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have pain in the jaw joint, ear or side of face?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you experienced:			
a) Difficulty in opening and closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Difficulty chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Head, neck, jaw or teeth injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Habits- Do you:			
a) Clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Are you unable to breath through your nose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had any of the following?			
a) Your teeth ground or your bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) A bite plate or any other oral appliance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Teeth extracted because of crowding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) If yes to any of the above, please explain:	_____		

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MEDICAL INFORMATION

Physician's Name: _____ Date of last physical exam: _____

For the following questions mark **yes, no or don't know (d/k)**

- | | yes | no | d/k |
|--|--------------------------|--------------------------|--------------------------|
| 1. Have you ever been hospitalized for any operation or illness?
If so, for what? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have any of the following diseases or problems: | | | |
| a) heart disease, rheumatic or scarlet fever, heart murmurs
or heart valve replacements? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) hepatitis, jaundice, mononucleosis, or pneumonia? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) fainting spells, dizziness, or seizures? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had radiation therapy for any disease of the head or neck? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does anyone in your family have any disability, birth defect,
or growth related problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant or do you think you might be? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you allergic to latex, nickel, red food dye, aspirin, penicillin
or any other drug?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any disease, condition or problem not listed that
we should know about?
_____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Please list all the medications that you are currently taking.
_____ | | | |
| 10. Are you currently under the care of a physician? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you reached puberty?
(boys: voice change, girls: commence menstruation) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Height: _____ Weight: _____

Realizing that successful treatment greatly depends upon patient cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____