American Association of
Orthodontists

Date: _____

CONFIDENTIAL

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

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Prefers To Be Called: _____

S.S.N./S.I.N.: _____ Home Phone No.: (_____)_____-_____

Patient's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

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 Birth Weight _____lbs._____oz. Patient's Present Weight _____lbs. Height _____ft. _____in.

Custodial Parent(s) or Guardian(s): _____ Phone No. (if different than patient's): (_____)_____-_____

Address (if different than patient's): _____

City: _____ State/Province: ___ Zip/Postal Code: _____

E-mail address:_____ Cell phone/pager:_____

Name Of Patient's Dentist: _____ Phone No.: (_____)_____-_____

Dentist's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen: _____ Reason: _____

Name Of Patient's Physician (s): _____ Phone No(s).: (_____)_____-_____

Physician's Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Date Last Seen:_____ Reason: _____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____ Middle Name/Initial: _____

Address (if different from patient's): _____ City:_____ State:_____ Zip:_____ Years at this address: _____

If less than five years, previous address: _____ City:_____ State:_____ Zip:_____

Phone No. (if different than patient's): (_____)_____-_____ S.S.N/S.I.N .:_____

Employer:_____ How many years?_____

Insurance Coverage For Dental Treatment? Yes ☐ No ☐ Insurance Coverage For Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employed By: _____

Dental Insurance Company: _____ Group No. _____

Medical Insurance Company:_____ Group No. _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐yes ☐no ☐dk/u Does patient follow directions well?

☐yes ☐no ☐dk/u Does patient brush his/her teeth conscientiously?

☐yes ☐no ☐dk/u Does patient have learning disabilities or need extra help with instructions?

☐yes ☐no ☐dk/u Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Birth defects or hereditary problems?

☐yes ☐no ☐dk/u Bone fractures, any major accidents?

☐yes ☐no ☐dk/u Rheumatoid or arthritic conditions?

☐yes ☐no ☐dk/u Endocrine or thyroid problems?

☐yes ☐no ☐dk/u Kidney problems?

☐yes ☐no ☐dk/u Diabetes?

☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?

☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?

☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis or pneumonia?

☐yes ☐no ☐dk/u Problems of the immune system?

☐yes ☐no ☐dk/u AIDS or HIV positive?

☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problem?

☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?

☐yes ☐no ☐dk/u Mental health disturbance or behavioral problem?

☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?

☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?

☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?

☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐yes ☐no ☐dk/u High or low blood pressure?

☐yes ☐no ☐dk/ u Tires easily?

☐yes ☐no ☐dk/u Chest pain, shortness of breath or swelling ankles?

☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

☐yes ☐no ☐dk/u Skin disorder?

☐yes ☐no ☐dk/u Does the patient eat a well-balanced diet?

☐yes ☐no ☐dk/u Frequent headaches, colds or sore throats?

☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?

☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?

☐yes ☐no ☐dk/u Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)

☐yes ☐no ☐dk/u Aspirin

☐yes ☐no ☐dk/u Ibuprofen (Motrin, Advil)

☐yes ☐no ☐dk/u Penicillin or other antibiotics

☐yes ☐no ☐dk/u Sulfa drugs

☐yes ☐no ☐dk/u Codeine or other narcotics

☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)

☐yes ☐no ☐dk/u Latex (gloves, balloons)

☐yes ☐no ☐dk/u Vinyl

☐yes ☐no ☐dk/u Acrylic

☐yes ☐no ☐dk/u Animals

☐yes ☐no ☐dk/u Foods (specify) _____

☐yes ☐no ☐dk/u Other substances (specify) _____

☐yes ☐no ☐dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

☐yes ☐no ☐dk/u Does the patient currently have or ever had a substance abuse problem?

☐yes ☐no ☐dk/u Does the patient chew or smoke tobacco?

☐yes ☐no ☐dk/u Operations? Describe: _____

☐yes ☐no ☐dk/u Hospitalized? For:_____

☐yes ☐no ☐dk/u Other physical problems or symptoms?

Describe: _____

☐yes ☐no ☐dk/ u Being treated by another health care professional?

For:_____

Date of most recent physical exam? _____

Are there any other medical conditions that we should be aware of?

_____

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?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders_____

Diabetes_____

Arthritis_____

Metabolic disturbances_____

Severe allergies_____

Unusual dental problems_____

Jaw size imbalance_____

Any other family medical conditions that we should know about?

_____

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Started teething very early or late?
☐yes ☐no ☐dk/u Primary (baby) teeth removed that were not loose?
☐yes ☐no ☐dk/u Permanent or "extra" (supernumerary) teeth removed?
☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?
☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?
☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?
☐yes ☐no ☐dk/u Periodontal "gum problems"?
☐yes ☐no ☐dk/u Food impaction between teeth?
☐yes ☐no ☐dk/u Thumb, finger, or sucking habit? Until what age _____?
☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no ☐dk/u History of speech problems?
☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?
☐yes ☐no ☐dk/u Tooth grinding, jaw clenching clicking or locking?
☐yes ☐no ☐dk/ u Any pain in jaw or ringing in the ears?
☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?
☐yes ☐no ☐dk/u Difficulty encountered in chewing or jaw opening?
☐yes ☐no ☐dk/u Aware of loose, broken or missing restorations (fillings)?
☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no ☐dk/u Concerned about spaced, crooked or protruding teeth?
☐yes ☐no ☐dk/u Aware or concerned about under or over developed jaw?
☐yes ☐no ☐dk/u "Gum Boils", frequent canker sores or cold sores?
☐yes ☐no ☐dk/u Taking any forms of fluoride?
☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?
☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
☐yes ☐no ☐dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
☐yes ☐no ☐dk/u Any serious trouble associated with any previous dental treatment?
☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?
☐yes ☐no ☐dk/u Been under another dentist's care?
Specialist _____
Other _____

How often does your child brush? _____ Floss? _____

What is your primary concern? Why are you here? _____

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental Staff Member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: ______________________________ Date Signed: ______________
(Parent or Guardian)
Signed: ______________________________ Date Signed ______________
(Dental Staff Member)

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