

# Medical Dental History Form for Patients Under Age 18

Date \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ Patient's First Name \_\_\_\_\_

Birth Date \_\_\_\_\_

Patient's Mailing Address \_\_\_\_\_

Patient's Email Address \_\_\_\_\_

Dentist Name \_\_\_\_\_ Dentist Phone Number \_\_\_\_\_

What concerns you about your child's teeth?

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Who suggest that you might need orthodontic treatment?

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## Parents/Guardian

Custodial Parent Name \_\_\_\_\_ Patient lives with \_\_\_\_\_

Father's Full Name \_\_\_\_\_ Father's Phone Number \_\_\_\_\_

Mother's Full Name \_\_\_\_\_ Mother's Phone Number \_\_\_\_\_

## Medical History

Birth Defect or Hereditary Problem? Yes No

Any injuries to face, head, neck? Yes No

Arthritis or joint problem? Yes No

Endocrine or thyroid Problems? Yes No

Diabetes or low sugar? Yes No

Kidney Problem? Yes No

- Cancer, tumor, radiation treatment or chemotherapy?  Yes  No
- Stomach ulcer, hyperacidity, acid reflux?  Yes  No
- Immune system problem?  Yes  No
- History of osteoporosis?  Yes  No
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?  Yes  No
- AIDS or HIV positive?  Yes  No
- Hepatitis, jaundice, or other liver problem?  Yes  No
- Polio, mononucleosis, tuberculosis, pneumonia?  Yes  No
- Seizures, Fainting spells, neurologic problems?  Yes  No
- Mental health disturbance or depression?  Yes  No
- Visio, hearing or speech problems?  Yes  No
- History of eating disorder?  Yes  No
- High or low blood pressure?  Yes  No
- Excessive bleeding or bruising, anemia?  Yes  No
- Chest pain, shortness of breath, tire easily, swollen ankles?  Yes  No
- Heart defects, heart murmur, rheumatic heart disease?  Yes  No
- Angina, arteriosclerosis, stroke, or heart attack?  Yes  No
- Skin disorder?  Yes  No
- Do you eat a well-balanced diet?  Yes  No
- Frequent headaches or migraines?  Yes  No
- Frequent ear infections, colds, throat infections?  Yes  No
- Asthma, sinus problems, hayfever?  Yes  No
- Tonsil or adenoid condition?  Yes  No
- Do you frequently breathe through mouth?  Yes  No
- Do you snore?  Yes  No
- Has your snoring ever bothered anyone?  Yes  No
- Has anyone noticed that you stop breathing during your sleep?  Yes  No
- Do you feel fatigued or tired after your sleep?  Yes  No
- During your waking time, do you feel tired, or fatigued?  Yes  No
- Have you ever fallen asleep while driving a vehicle?  Yes  No

## Have you had allergies or reactions to any of the following?

Local anesthetics (novocaine, lidocaine, xylocaine)  Yes  No

- Latex (gloves, balloons)  Yes  No
  - Aspirin  Yes  No
  - Metals (jewelry, clothing snaps)  Yes  No
  - Penicillin  Yes  No
  - Other antibiotics  Yes  No
  - Ibuprofen (Motrin, Advil), Acrylics  Yes  No
  - Plant pollens  Yes  No
  - Animals  Yes  No
  - Foods  Yes  No
  - Other substances  Yes  No
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## Dental History

- Permanent or extra (supernumerary) teeth removed?  Yes  No
- Supernumerary (extra) or congenitally missing teeth?  Yes  No
- Chipped or injured primary or permanent teeth?  Yes  No
- Any sensitive or sore teeth?  Yes  No
- Bleeding gums, bad taste or mouth odor?  Yes  No
- Jaw fractures, cysts, infections?  Yes  No
- Any teeth, treated with root canals or pulpotomies?  Yes  No
- Gum boils, frequent cancer sores or cold sores?  Yes  No
- History of speech problems or speech therapy?  Yes  No
- Difficulty breathing through nose?  Yes  No
- Food impaction between the teeth?  Yes  No
- Mouth breathing habit or snoring at night?  Yes  No
- Frequent oral habits (sucking finger, chewing pen)?  Yes  No
- Teeth causing irritation to lip, cheek or gums?  Yes  No
- Abnormal swallowing (tongue thrust)?  Yes  No
- Tooth grinding or clenching?  Yes  No
- Clicking, locking in jaw joints?  Yes  No
- Soreness in jaw muscles or face muscles?  Yes  No
- Ringing in ears, difficulty in chewing or opening jaw?  Yes  No
- Have you ever been treated for TMJ or TMD problems?  Yes  No

Any broken or missing fillings?

Yes  No

Any serious trouble associated with previous dental treatment?  Yes  No

Have you ever been diagnosed with gum disease?  Yes  No

Have you ever had an orthodontic consultation or treatment before now?  Yes  No

## List of any Medications

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## Release and Waiver

I authorize release of any information regarding my orthodontic treatment to my dental or medical insurance company.

Signature:

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Parent/Guardian Full Name

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Parent/Guardian Signature

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Date

Date:

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