

PATIENT HISTORY FORM

Patient's (First, Middle, Last)
Name _____

Nickname _____ Sex _____ Age _____ Birthdate _____

Patient's
Address _____ E-Mail _____

Patient's Home Phone _____

Patient's School _____ Grade _____ Hobbies/Interests _____

Mother's
Name _____ Address _____ Employer _____

Cell# _____ Wk Phone # _____

Father's
Name _____ Address _____ Employer _____

Cell# _____ Wk Phone # _____

Parent Status M D S W _____

Any family member in treatment or treated here? _____

How did you first become aware of your need for orthodontic treatment? _____

Referred by _____ Dental/Ortho Insurance Y N _____

DENTAL HISTORY AND DEVELOPMENT QUESTIONNAIRE

Patient's
D.D.S. Name/Address _____ D.D.S. Phone _____

Previous Ortho-
dontic Treatment Y N Length of Treatment _____ Orthodontist _____ Parents had Orthodontic
Treatment Y N

Comments on any
Dental Trauma: _____

- 1. Any problems with your teeth or gums? Y N
- 2. Do you play a musical instrument? Y N
- 3. Do you play a contact sport? Y N
If yes, which sport _____
- 4. Last dental visit? _____
- 5. Any trouble with previous dental treatment? Y N
If so, please explain _____
- 6. Any problems with speech? Y N (if yes, please specify)

- 7. Do you bite your nails? Y N (if yes, please specify and until what age?)

- 8. Any thumb, pacifier or finger after 3? Y N
- 9. Do you grind or clench your teeth? Y N
- 10. Any problems with frequent jaw clicking, jaw popping
head aches or neck aches? Y N

Primary Dental Concerns:

Primary Orthodontic Concerns:

PATIENT HISTORY FORM, CONT.

Patient's (First, Middle, Last)

Name _____

MEDICAL HISTORY

Operations:

Tonsils removed? Y N Adenoids removed? Y N

Other _____

Presently taking What For
any Medications? Y N Meds _____ What _____

Any Medical Issues that require antibiotics before dental procedures? _____

Allergies: Any known allergies to Medications? Y N If yes, what meds? _____

Do you have any known allergies to Nickel? Y N Latex? Y N

Other allergies? _____

Now or in the past, have you had:

- | | | | |
|--|-----|--|-----|
| 1. Birth defects or hereditary problems? | Y N | 16. Loss of weight recently, poor appetite? | Y N |
| 2. Bone fractures, any major accidents? | Y N | 17. History of eating disorder (anorexia, bulimia) | Y N |
| 3. Rheumatoid or arthritic conditions? | Y N | 18. Excessive bleeding or bruising tendency, anemia | |
| 4. Endocrine or thyroid problems? | Y N | or bleeding disorder? | Y N |
| 5. Kidney problems? | Y N | 19. High or low blood pressure? | Y N |
| 6. Diabetes? | Y N | 20. Tire easily? | Y N |
| 7. Cancer, tumor, radiation treatment | | 21. Chest pain, shortness of breath or swelling ankles? | Y N |
| or chemotherapy? | Y N | 22. Cardiovascular problem (heart trouble, heart attack, | |
| 8. Stomach ulcer or hyperacidity? | Y N | angina, coronary insufficiency, arteriosclerosis, | |
| 9. Polio, mononucleosis, tuberculosis, | | stroke, inborn heart defects, heart murmur or | |
| pneumonia? | Y N | rheumatic heart disease)? | Y N |
| 10. Problems of the immune system? | Y N | 23. Skin disorder? | Y N |
| 11. AIDS or HIV positive? | Y N | 24. Frequent headaches, colds or sore throats | Y N |
| 12. Hepatitis, jaundice or liver problem? | Y N | 25. Eye, ear, nose or throat condition? | Y N |
| 13. Fainting spells, seizures, epilepsy | | 26. Hay fever, asthma, sinus trouble or hives? | Y N |
| or neurological problem? | Y N | 27. Tonsil or adenoid conditions? | Y N |
| 14. Mental health disturbance or depression? | Y N | 28. Osteoporosis? | Y N |
| 15. Vision, hearing, tasting or speech | | 29. Height of birth parent: Mother _____ Father _____ | |
| difficulties? | Y N | | |

Patient's
M.D. _____ M.D. Phone _____

M.D. Address _____

If you answered "yes" to any of the questions above, please provide details below and specify the question number.

To the best of my knowledge the above is complete and correct. I hereby give permission for dental treatment to be accomplished and for the development of photographic recordings of the conditions and treatment for the advancement of Dental Science through use in professional publications, lectures or television presentations.

Signature (patient, parent or guardian)

Date