Confidential Medical/Dental History

Patient Name ________________________ DOB ____________ Age ______

Address ____

Primary Phone ______________________________

Primary Care Dentist __________________________ Primary Physician __________________________

For the following question please circle **YES, NO or DON'T KNOW/UNDERSTAND**. The answers are for office records only & will be considered confidential. These answers are for **PATIENT history ONLY,** not family history.

MEDICAL HISTORY

Yes No dk/u Are you in good health? Date of most recent physical exam? ______________________

Yes No dk/u Latex allergy, Nickel allergy, Drug allergies. Specify:______________________

Yes No dk/u Cardiovascular problems (heart murmur, MVP, inborn heart defect, rheumatic heart, heart failure, angina, stroke, coronary insufficiency, arteriosclerosis, heart trouble). Please Specify: ______________________

Yes No dk/u Joint replacement or other surgically implanted device: ______________________

Yes No dk/u Have you ever been instructed to take antibiotic or pre-medication BEFORE dental appt? ______________________

Yes No dk/u History of rheumatic fever, stomach ulcer/hyperacidity, polio, tuberculosis, mononucleosis, pneumonia. Specify______________________

Yes No dk/u Personal patient history of cancer or tumor. Specify:______________________

Yes No dk/u Have you taken a bisphosphonate drug? (Fosamax, Zometa, Didronel, Reclast, Boniva, Actonel, Aclasta, Atelvia, Aredia, Binosto, Skelid) IV or Oral ____________

Yes No dk/u Current medications. Specify:______________________

____

Yes No dk/u Chronic sinus trouble, Ear/Nose/Throat conditions, Tonsil/Adenoid condition. Specify:______________________

Yes No dk/u Frequent headaches/colds/sore throats, vision/hearing/taste difficulty. Specify:______________________

Yes No dk/u Hepatitis, jaundice, liver problems, AIDS or HIV positive, STD's. Specify: ______________________

Yes No dk/u High or Low Blood Pressure, diabetes, chest pain, swollen ankles, shortness of breath. Specify:______________________

Yes No dk/u Fainting spells, seizures, epilepsy, neurologic disease. Specify:______________________

Yes No dk/u Anemia, excessive bleeding, bleeding disorder. Specify:______________________

Yes No dk/u ADD, ADHD, mental health or behavioral problems. Specify: ______________________

Yes No dk/u Endocrine, thyroid, kidney problems. Specify:______________________

Yes No dk/u Birth defects, hereditary problems, cleft lip/palate, speech problems. Specify:______________________

Yes No dk/u Asthma. Asthma emergency? Specify:______________________

Yes No dk/u History of tobacco, alcohol or substance abuse, eating disorder. Specify:______________________

Yes No dk/u Rheumatoid/arthritic conditions. Specify:______________________

Yes No dk/u Operations or hospitalizations? Specify:______________________

Yes No dk/u Currently being treated by medical professional? Please specify reason:______________________

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FEMALE PATIENTS

Yes No dk/u Are you pregnant? If yes, due date:______________ Yes No dk/u Are you taking birth control pills? Yes No dk/u Anticipate pregnancy in next 3 years?

DENTAL HISTORY

Primary concern/what made you come to the orthodontist?____

Yes No dk/u Past or current injury to teeth, face or jaws. Specify:____

Yes No dk/u Current toothache or abnormally sensitive teeth. Specify:____

Yes No dk/u Current thumb-sucking or other oral habit. Specify:____

Yes No dk/u Snoring, clenching, grinding, open-mouth posture. Specify:____

Yes No dk/u Jaw joint sounds/popping, jaw pain. Specify:____

Yes No dk/u Jaw joint problems in other members of your immediate family. Specify: ____

Yes No dk/u Past or current difficulty opening/closing; TMJ difficulties. Specify:____

Yes No dk/u Periodontal or gum disease, previous treatment. Doctor/date:____

Yes No dk/u Hereditary tooth/jaw problems. Specify:____

Yes No dk/u Previous orthodontic treatment. Doctor/date:____

Yes No dk/u Any dental work in progress? ____

Date of last dental exam:______________________ How often do you brush?:______________________ Floss:______________

Yes No dk/u Any restrictions, handicaps or problems that will limit patient from maintaining oral hygiene, keeping appointments and following instructions?

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I have read & understand the above questions. I will not hold my orthodontist or any member of his 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 records or medical/dental status, I will so inform this practice.

______________________________ Signature of Patient Date

______________________________ COMMENT Doctor Signature Date

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Medical History Updates: (Staff use only)

______________________________ Change/Addition to Medical/Dental History Patient Signature Date

______________________________ COMMENT Doctor initials Date

______________________________ Change/Addition to Medical/Dental History Patient Signature Date

______________________________ COMMENT Doctor initials Date

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