MEDICAL HISTORY FORM **DATE:**______________________

PATIENT NAME:____ **DOB:**_____________________
DENTIST:____

How did you hear about our office? ☐ Dentist ☐ Family ☐ Friend ☐ Other
If Other, please describe (i.e. sign, Google, etc.)____
Name of referring party?____
Have any other family members been treated here? ☐ Yes ☐ No If Yes, Whom?_____________________
Have you previously had orthodontic treatment? ☐ Yes ☐ No
Have there been injuries to the face, mouth, or teeth? ☐ Yes ☐ No If Yes, Please describe:
____
Has the patient traveled outside the U.S. within the last 30 days? ☐ Yes ☐ No Location:________________

CHIEF COMPLAINT(s):

☐ Crowding
☐ Spacing
☐ Overbite
☐ Underbite
☐ Crossbite
☐ TMJ Problems
☐ Excessive Wear
☐ Protrusion
☐ Mis-shaped teeth
☐ Receded Jaw
☐ Gummy Smile
☐ Prominent Jaw
☐ Missing Teeth
☐ Speech Problems
☐ Difficulty Chewing
☐ Facial Proportions
☐ Thumb/Finger Habit
☐ Teeth are Loose
☐ Gum Disease
☐ Receding Gums
☐ Clenching
☐ Openbite
☐ Dizziness
☐ Retained Baby Tooth
☐ Difficulty Opening
☐ Difficulty Closing
☐ Grinding
☐ Jaw Locks Open
☐ Difficulty Swallowing

HAVE YOU EXPERIENCED:

☐ Blood Transfusion
☐ Accidental Injury
☐ Blood Disorder
☐ Major/Minor Surgery
☐ ADD
☐ ADHD

MEDICAL HISTORY:

☐ None
☐ Cold Sores
☐ Frequent sinusitis
☐ Sore throats
☐ Allergies
☐ Ear Infections
☐ Autoimmune Disease
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Epilepsy
☐ Blood Disorder
☐ Diabetes
☐ Smoker – Present
☐ Smoker – Past
☐ Osteoporosis
☐ Hepatitis A, B or C
☐ HIV or AIDS
☐ Hx of Major Illness
☐ Fever
☐ Flu like Symptoms

Current Health: ☐ Good ☐ Problems

PATIENT NAME:____ **DOB:**_____________________

MEDICATIONS TAKING NOW:

☐ None ☐ Yes

List Medications:____

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ALLERGIES OR SENSITIVITIES:

☐ None ☐ Metal

☐ Drug ☐ Latex

List:____

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PREMEDICATION REQUIRED?

☐ No ☐ Yes – Heart Valve ☐ Yes – Artificial Joint

☐ Yes – Heart Murmur ☐ Yes – Rheumatic Fever ☐ Other

HABITS:

☐ None ☐ Finger – Past ☐ Lip Sucking

☐ Thumb – Present ☐ Tooth Grinding –Present ☐ Pacifier – Prolonged

☐ Thumb – Past ☐ Tooth Grinding – Past ☐ Tooth Clenching – Present

☐ Finger – Present ☐ Lip Biting ☐ Tooth Clenching – Past

How frequently does the patient have dental check-ups?

☐ Once a year ☐ Three times a year ☐ Emergency only

☐ Twice a year ☐ Four times a year ☐ Never

Brushing frequency:

☐ Rarely ☐ Once a day ☐ Three times a day

☐ Every other day ☐ Twice a day ☐ After meals

Flossing frequency:

☐ Never ☐ Once a day ☐ After meals

☐ Rarely ☐ Twice a day

☐ Occasionally ☐ Three times a day

Supplemental rinses or gel?

☐ No ☐ Fluoride ☐ Antiplaque

PATIENT NAME:____ **DOB:**_____________________

TMJ SCREENING: (Chief Complaints Relative to TMJ/Head/Neck/Back)

- ☐ None
- ☐ Headaches/Frequent
- ☐ Headaches/Intermittent
- ☐ Clicking
- ☐ Popping
- ☐ Grating
- ☐ Locking
- ☐ Difficulty Opening
- ☐ Pain When Eating
- ☐ Ringing/Buzzing
- ☐ Difficulty Closing
- ☐ Limited Opening
- ☐ Condyles Remodeled
- ☐ Dizziness
- ☐ Deviation on Opening
- ☐ "Lightheaded"
- ☐ Post Nasal Drainage
- ☐ Sinusitis
- ☐ Allergies
- ☐ Chronic Sore Throat
- ☐ Frequent Tonsilitis
- ☐ Earaches

MEDICAL HISTORY COMMENTS:

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