



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)

**MEDICAL HISTORY UPDATE OR CHANGES**

Comments: \_\_\_\_\_

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Parent or Guardian)

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