DR. GEORGE WALKER ORTHODONTICS
MEDICAL DENTAL HISTORY FORM
FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____
Patient Last Name_____First_____Middle_____
Birth date_____ Age____ Sex____ Patient Cell#_____ Patient E-mail_____
Parent or custodial adult name(s)_____ Relationship to patient_____
Address_____E-mail_____
Home Phone#_____ Best Immediate contact# (Cell/work)_____
Parent is ___Single ___Married ___Widowed ___Separated ___Divorced ___Divorced and remarried
Additional Responsible Party Name (s)_____ Relationship to Patient_____
Address_____ Phone#_____

Name of Patient's Dentist_____ Date of Last Dental Exam/Cleaning_____
Name of Patient's Physician_____ Date of last Physical_____

Patient's School_____
Number of Siblings_____ Ages _____ Other Family Member's Treated_____
Hobbies/Sports/ Instruments Played_____

For the following questions **please circle yes, no, or don't know/understand (dk/u). Please also circle the specific condition applicable.** 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?

Yes No dk/u Does patient have learning disabilities or need help with instructions?

Yes No dk/u Does patient have a normal and good diet?

Yes No dk/u Is patient sensitive, self-conscious?

Yes No dk/u Is patient having social difficulty related to tooth alignment (getting teased, not smiling, etc.)?

Yes No dk/u Does patient brush his/her teeth conscientiously?
How often does patient brush_____ floss_____

----------DENTAL HISTORY----------

Yes No dk/u Started teething 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 Any dental or facial trauma?

Yes No dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

Yes No dk/u "Dead teeth", root canals treated?

Yes No dk/u Jaw fractures, cysts, mouth infections?

Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?

Yes No dk/u Periodontal "Gum problems"?

Yes No dk/u Any previous periodontal (gum) treatments?

Yes No dk/u "Gum boils", frequent canker sores, cold sores?

Yes No dk/u Bleeding gums, bad taste, mouth odor?

Yes No dk/u Food impaction between teeth?

Yes No dk/u History of speech problems?

Yes No dk/u Abnormal swallowing habit (tongue thrusting)?

Yes No dk/u Thumb or finger sucking habit? Stopped when? _____

Yes No dk/u Difficulty chewing or opening jaw?

Yes No dk/u Aware of loose, broken, or missing restorations (fillings)?

Yes No dk/u Is child taking any form of fluoride?

Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?

Yes No dk/u Any wisdom tooth problems?

Yes No dk/u Has patient had any problems associated with previous dental treatment?

Yes No dk/u Has patient had a prior orthodontic examination or treatment?
When? _____Type of treatment _____

Please check all concerns: ___ spaces ___crowding (not enough space) ___ crossbite ___alignment (crooked teeth) ___protruding teeth ___missing teeth ___ jaw growth problem ___room for permanent tooth eruption ___impacted teeth ___general dentist recommendation/concern_____ ___Other_____

Yes No dk/u Any relative with similar tooth or jaw relationship?

Yes No dk/u Would the patient object to wearing orthodontic appliance (braces) should they be indicated?

Yes No dk/ Has the patient had recent dental care? or specialists care?_____

Please continue with the medical history on the reverse side

MEDICAL HISTORY

Yes No dk/u Birth defects, hereditary conditions?

Yes No dk/u Bone fractures, any major accidents?

Yes No dk/u Rheumatic or arthritic condition?

Yes No dk/u Mental health or behavioral problem?

Yes No dk/u ADD or ADHD?

Yes No dk/u Kidney problem?

Yes No dk/u Endocrine or thyroid problem?

Yes No dk/u Vision, hearing, tasting, or speech difficulties?

Yes No dk/u Cancer or been treated for a tumor?

Yes No dk/u Stomach ulcer or stomach hyperactivity?

Yes No dk/u Polio, mono, tuberculosis, pneumonia?

Yes No dk/u Problems of the immune system?

Yes No dk/u Tonsil or adenoid condition or treatment?

Yes No dk/u High or low blood pressure?

Yes No dk/u Fainting spells, seizures, epilepsy or neurological problem?

Yes No dk/u Chest pain, shortness of breath, swelling ankles?

Yes No dk/u Tires easily?

Yes No dk/u Cardiovascular problem: heart trouble, heart attack, angina, coronary insufficiency, stroke, arteriosclerosis, heart defect or rheumatic heart?

Yes No dk/u Mouth breathing habit or difficulty in breathing?

Yes No dk/u Feel tired, fatigued, sleepy during the day?

Is pre-medication for dental procedures recommended?_____

*Please list all medications, non-prescription medicine (for what condition), & nutrient supplements patient is currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Yes No dk/u Does patient regularly take aspirin or other NSAIDS (non-steroidal anti-inflammatory medication)?
For what condition? _____

Yes No dk/u Diabetes?

Yes No dk/u Loss of weight recently, poor appetite?

Yes No dk/u Excessive bleeding, bruise easily, anemia, or bleeding disorder?

Yes No dk/u Onset of puberty(what age or approximate date)_____

Yes No dk/u Growth (increase in height) in last 12 months_____

Yes No dk/u Mouth breathing habit, snoring, difficulty in breathing?

Yes No dk/u Eye, ear, nose, throat condition?

Yes No dk/u Seasonal allergies, hay fever, asthma, sinus trouble, hives?

Yes No dk/u Drug reactions?_____

Yes No dk/u Skin disorder?

Yes No dk/u Allergy to latex, nickel or any metal?

Yes No dk/u AIDS or HIV positive?

Yes No dk/u Hepatitis, jaundice, or liver problem?

Yes No dk/u Frequent colds, headaches, or sore throats?

Yes No dk/u Tooth grinding, jaw clenching, clicking, or locking?

Yes No dk/u Any pain in jaw?

Yes No dk/u Does patient experience any pain or soreness in the muscles of the face or around the ears?

Yes No dk/u Snore loudly enough to be heard through closed doors?

Yes No dk/u Has anyone observed the patient stop breathing while asleep?

Yes No dk/u Does patient currently have, or ever had a substance abuse problem?

Yes No dk/u Operations (surgical procedures)?_____

Yes No dk/u Hospitalized for _____date_____

Yes No dk/u Being treated by another health care professional?
For_____

Yes No dk/u Other physical problems or symptoms?_____
_____

Realizing that successful orthodontic treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment? Yes No If yes, please specify:

_____

I have read and understood 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 inform this practice.

Signature of parent or guardian/Date

Medical history update or changes

Date	Comments/Changes	Signature