



**American Association of Orthodontists
MEDICAL DENTAL HISTORY FORM FOR
PATIENTS UNDER 18 YEARS OF AGE**

Date: _____

CONFIDENTIAL

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male Female I Prefer 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: _____

- 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? Describe: _____

 - 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 or jaw clenching?
- 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 you 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)

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Comments: _____

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(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)

MEDICAL HISTORY UPDATE OR CHANGES

Comments: _____

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental staff member)