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ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

• WELCOME TO OUR OFFICE. TELL US ABOUT YOURSELF •

Patient Name: ______ Date of Birth: ______ Gender: ______

Home Address: ______ Home Phone: ______

City: ______ Postal Code: ______ Work Phone: ______

Email: ______ Cell Phone: ______

PLEASE MARK PREFERRED METHOD OF COMMUNICATION

Emergency Contact

Name: ______ Phone (Residence): Phone (Cell): ______

Relationship: ______

	Family Dentist	Family Physician	Referred By
Name:	______	______	______
Address:	______	______	
Telephone:	______	______	

Medical History ❑ No To All

Have you ever had?

Y N Allergy-(if yes, note in comments)	Y N Cold Sores	Y N Head or Face Injury	Y N Oral Ulceration
Y N Anemia	Y N Diabetes	Y N Hemophilia/Bleeding Problems	Y N Previous Surgery
Y N Arthritis	Y N Endocrine Problems	Y N Hepatitis	Y N Rheumatic Fever
Y N Artificial Joints/Valves	Y N Emotional Problems	Y N Herpes	Y N Thyroid Problems
Y N Asthma/Difficulty Breathing	Y N Epilepsy/Seizures	Y N HIV Positive	Y N Tuberculosis
Y N Birth Defects/Congenital Defects	Y N Headache/Migraine	Y N Kidney/Liver Disease	Y N High/Low Blood Pressure
Y N Cancer	Y N Heart Condition/Murmur	Y N Mitral Valve Prolapse	Y N **Other**(Describe Below)

Comments ______

______

Do you have Drug / Food Allergies: Y N If Yes, please list: ______

______

Have you been under the care of the physician during the past two years, other than for routine examination?

No ❑ Yes ❑ Condition: ______

Do you require pre-medication (antibiotics) for dental procedures? No ❑ Yes ❑

Present drugs or medication: ______

Respiratory History Do you:

1. Have allergies to?: Latex: ______ Metal: ______
   Seasonal: ______ Other: ______
2. Breathe through the mouth? Seldom ❑ Sometimes ❑ Always ❑ When? Daytime ❑ or Night-time ❑
3. Snore when sleeping? No ❑ Yes ❑
4. Have frequent colds? No ❑ Yes ❑
5. Have frequent "stuffy nose"? No ❑ Yes ❑
6. Have frequent sore throat or tonsillitis? No ❑ Yes ❑
7. Have chewing or swallowing difficulties? No ❑ Yes ❑
8. Have you received medical treatment from an allergist or ear, nose, and throat (ENT) specialist? No ❑ Yes ❑
   If Yes: When ______ By whom: ______
   Nasal Surgery: ______ Tonsils Removed: ______ Adenoids Removed: ______

Dental and Temporomandibular Joint History

Have you had any unusual dental experiences? No ❑ Yes ❑

Specify:____

Date of last dental checkup:________________________ Were your teeth cleaned? No ❑ Yes ❑

Have you ever been treated for TMJ (TMD or “Jaw Joint”) problems? No ❑ Yes ❑

Do you have?

1. Difficulty in mouth opening? No ❑ Yes ❑
2. Pain or clicking in the jaw joint? No ❑ Yes ❑
3. Pain on chewing, yawning, or opening wide? No ❑ Yes ❑
4. Pain in or about the ears or cheeks? No ❑ Yes ❑
5. A bite that feels “uncomfortable” or “unusual”? No ❑ Yes ❑
6. A jaw that “locks”, “gets stuck” or “goes out”? No ❑ Yes ❑
7. Noises in or from the jaw joint No ❑ Yes ❑

The following habits are of interest. List information as it pertains to you:

1. Thumb/finger/lip sucking until__________(age) No ❑ Yes ❑
2. Grinding or clenching of the teeth No ❑ Yes ❑
3. Tongue thrusting or other functional problems No ❑ Yes ❑

Have you had a previous orthodontic consultation? No ❑ Yes ❑ Or treatment? No ❑ Yes ❑

Date:______________________Dr.________________________City, Province:____________________________

Why do you seek this consultation?____

____

What is the primary problem (chief complaint)?____

____

____

____

What is expected from orthodontic treatment?____

____

____

How important are the following with orthodontic treatment (circle all that are applicable): 1. Visibility 2.Length of treatment 3.Comfort 4. Convenience

Signature:____Date:_______________