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ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

☻ Welcome to our office ☻

Patient Name: _____ Date of Birth: _____ Gender: _____

Responsible Party 1 Name: _____ Responsible Party 2: _____

RP 1 Address: _____ RP 2 Address: _____

City: _____ Postal Code: _____ City: _____ Postal Code: _____

RP 1 Home Number: _____ RP 2 Home Number: _____

RP 1 Work Number: _____ RP 2 Work Number: _____

RP 1 Cell Number: _____ RP 2 Cell Number: _____

RP 1 Email: _____ RP 2 Email: _____

PLEASE MARK PREFERRED METHOD OF COMMUNICATION ABOVE

	Family Dentist	**Family Physician**	**Referred By**
Name:	_____	_____	_____
Address:	_____	_____	
Telephone:	_____	_____	

Medical History ❑ No To All

Has your child 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: _____

Does he/she have Drug / Food Allergies: Y N If Yes, please list: _____

Has the patient been under the care of the physician during the past two year, other than for routine examination?

No ❑ Yes ❑ Condition: _____

Does the patient require pre-medication (antibiotics) for dental procedures? No ❑ Yes ❑

Present drugs or medication: _____

Growth Indication: Has the patient reached puberty or not? No ❑ Yes ❑
Girls-has she reached menstruation? No ❑ Yes ❑
Boys-has his voice changed? No ❑ Yes ❑

Please see other side

Respiratory History

Does the patient:

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. Has the patient 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

Has the patient had any unusual dental experiences? No ❑ Yes ❑

Specify: _____

Date of last dental checkup: _____ Were patient's teeth cleaned? No ❑ Yes ❑

Has the patient ever been treated for TMJ (TMD or "Jaw Joint") problems? No ❑ Yes ❑

Does the patient 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 the patient:

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 ❑

Has the patient had a previous orthodontic consultation? No ❑ Yes ❑ Or treatment? No ❑ Yes ❑

Date: _____ Dr. _____ City, Province: _____

Why did patient seek this consultation? _____

_____

What is the primary problem (chief complaint)? _____

_____

What is expected from orthodontic treatment? _____

_____

Signature: _____ Relationship: _____ Date: _____