PATIENT MEDICAL AND DENTAL HISTORY

What are the main concerns that you would like orthodontics to address? _____

_____

_____

Has your child had or does your child currently have the following:	Currently	Previously	Never
Previous orthodontic treatment	☐	☐	☐
Injury to the face, mouth, teeth or chin	☐	☐	☐
Jaw pain or other TMD/TMJ symptoms	☐	☐	☐
Speech problems	☐	☐	☐
Thumb or finger sucking habit	☐	☐	☐
Premedication prior to dental appointments	☐	☐	☐
Smoke or use tobacco products	☐	☐	☐
Periodontal disease (bone loss)	☐	☐	☐
For women: Are you pregnant?	☐	☐	☐
For women: Are you nursing?	☐	☐	☐
Dental Pain	☐	☐	☐
Teeth/jaw clinching (bruxism)	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Dental anxiety / fear of the dentist	☐	☐	☐
Excessive bleeding, bruising/bleeding disorder	☐	☐	☐
Cardiovascular / heart problems	☐	☐	☐
Eating disorder (anorexia, bulimia)	☐	☐	☐
Mental health disturbance or depression	☐	☐	☐
Tonsil or adenoid conditions	☐	☐	☐
Diabetes	☐	☐	☐
Substance abuse (alcohol, drugs)	☐	☐	☐
Any other pertinent medical condition	☐	☐	☐

Please explain any positive responses: _____

_____

_____

Recent treatments or hospitalizations: _____

_____

Does your child have any allergies or reactions to the following:	Yes	No
Local anesthetics (Novocain, Lidocaine)	☐	☐
Ibuprofen (Motrin, Advil) or aspirin	☐	☐
Codeine or other pain medication	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Other medications _____	☐	☐
_____		
Metals (jewelry, clothing snaps)	☐	☐
Latex (gloves, balloons, bandages)	☐	☐
Any other allergies, including food: _____	☐	☐
_____		

Has your child ever been diagnosed with:	Yes	No
Tuberculosis	☐	☐
AIDS / HIV	☐	☐
Artificial bones/joints/valves	☐	☐
Congenital heart defect	☐	☐
Hepatitis	☐	☐
Rheumatic/Scarlet Fever	☐	☐
Has your child ever taken bisphosphonates (medication for osteoporosis and some cancers)?	☐	☐

If so, how long ago did you start taking them? _____

How long was he/she you on them? _____

Has your child ever had a negative/traumatic experience in a dental office? ☐ ☐

Please let us know of any other things that you feel are important for us to know about your child _____

_____

Patient's School: _____ Year in school: _____

I have read and understand the above questions and have answered them correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic service on my child.

_____

Patient's signature Date

johnsonlink ORTHODONTICS