



Date: \_\_\_\_\_

CONFIDENTIAL

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

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: \_\_\_\_\_

Attend School At: \_\_\_\_\_

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 number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail address \_\_\_\_\_

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 than patient's) \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Years at this address \_\_\_\_\_

If less than five years, previous address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone No. (if different than patient's): \_\_\_\_\_ S.S.N./S.I.N.: \_\_\_\_\_

Insurance Coverage for Dental Treatment? Yes  No  Insurance Coverage For Orthodontic Treatment? Yes  No

Primary Policy Holder's Name: \_\_\_\_\_ S.S.N./S.I.N.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed By: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group No. : \_\_\_\_\_

Secondary Policy Holder's Name: \_\_\_\_\_ S.S.N./S.I.N.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Employed By: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_ Group No. \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Group No. \_\_\_\_\_

Who suggested that your child might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

**For the following questions mark yes, no, or don't know/understand (dk/u). 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 well?
- yes no dk/u Does Patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

yes no dk/u Skin disorder?

yes no dk/u Does the patient eat a well-balanced diet?

yes no dk/u Frequent headaches, colds or sore throats?

yes no dk/u Eye, ear, nose or throat condition?

yes no dk/u Hayfever, asthma, sinus trouble or hives?

yes no dk/u Tonsil or adenoid conditions?

**MEDICAL HISTORY**

**Now or in the past, have you had:**

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Mental health disturbance or depression?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tired easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?

**Allergies or reactions to any of the following:**

yes no dk/u Local anesthetics (Novocaine or Lidocaine)

yes no dk/u Aspirin

yes no dk/u Ibuprofen (Motrin, Advil)

yes no dk/u Penicillin or other antibiotics

yes no dk/u Sulfa drugs

yes no dk/u Codeine or other narcotics

yes no dk/u Metals (jewelry, clothing snaps)

yes no dk/u Latex (gloves, balloons)

yes no dk/u Vinyl

yes no dk/u Acrylic

yes no dk/u Animals

yes no dk/u Foods (specify) \_\_\_\_\_

yes no dk/u Other substances (specify) \_\_\_\_\_

yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

Medication \_\_\_\_\_ Taken for \_\_\_\_\_

**DENTAL HISTORY**

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? \_\_\_\_\_

**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? \_\_\_\_\_

Questions: \_\_\_\_\_

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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(Dental Staff Member)