Confidential Medical and Dental History

Patient name: _____ **Date:** _____

MEDICAL HISTORY

Now or in the past have you had: [Please mark all answers yes, no or don't know/don't understand (dk/u)]

Birth defects or hereditary problems?	yes ☐	no ☐	dk/u ☐	Vision, hearing, tasting, or speech difficulties?	yes ☐	no ☐	dk/u ☐
Bone fractures, any major accidents?	yes ☐	no ☐	dk/u ☐	Loss of weight recently, poor appetite?	yes ☐	no ☐	dk/u ☐
Rheumatoid or arthritic conditions?	yes ☐	no ☐	dk/u ☐	History of eating disorder (anorexia or bulimia)?	yes ☐	no ☐	dk/u ☐
Endocrine or thyroid problems?	yes ☐	no ☐	dk/u ☐	Excessive bleeding or bruising tendency, anemia, or bleeding disorder?	yes ☐	no ☐	dk/u ☐
Kidney problems?	yes ☐	no ☐	dk/u ☐	High or low blood pressure?	yes ☐	no ☐	dk/u ☐
Diabetes?	yes ☐	no ☐	dk/u ☐	Tired easily?	yes ☐	no ☐	dk/u ☐
Cancer, tumor, radiation treatment, or chemotherapy?	yes ☐	no ☐	dk/u ☐	Chest pain, shortness of breath or swelling ankles?	yes ☐	no ☐	dk/u ☐
Stomach, ulcer or hyperacidity?	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 ☐
Polio, mononucleosis, tuberculosis, pneumonia?	yes ☐	no ☐	dk/u ☐	Skin disorder?	yes ☐	no ☐	dk/u ☐
Problems of the immune system?	yes ☐	no ☐	dk/u ☐	Do you have a well-balanced diet?	yes ☐	no ☐	dk/u ☐
AIDS or HIV positive?	yes ☐	no ☐	dk/u ☐	Frequent headaches, colds or sore throats?	yes ☐	no ☐	dk/u ☐
Hepatitis, jaundice or liver problem?	yes ☐	no ☐	dk/u ☐	Eye, ear nose or throat condition?	yes ☐	no ☐	dk/u ☐
Fainting spells, seizures, epilepsy or neurological problem?	yes ☐	no ☐	dk/u ☐	Hay fever, asthma, sinus trouble or hives?	yes ☐	no ☐	dk/u ☐
Mental health, disturbance or depression?	yes ☐	no ☐	dk/u ☐	Tonsil or adenoid conditions?	yes ☐	no ☐	dk/u ☐
Osteoporosis?	yes ☐	no ☐	dk/u ☐				

Please use this space for any additional relevant information:	

Allergies or reactions to any of the following? If so please explain.

Local anesthetics (Novocain 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	yes ☐	no ☐	dk/u ☐	Specify:
Other substances	yes ☐	no ☐	dk/u ☐	Specify:
Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers, such as Zomete (zolendronic acid), Aredia (pamidronate), Didronel (etidronate)?	yes ☐	no ☐	dk/u ☐	Medications: Length of time taken:
Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia, or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), Didronel (etidronate)? Please name the medications and length of time taken.	yes ☐	no ☐	dk/u ☐	Medications: Length of time taken:
Do you currently have or ever had a substance abuse problem?	yes ☐	no ☐	dk/u ☐	
Do you chew or smoke tobacco?	yes ☐	no ☐	dk/u ☐	
Operations?	yes ☐	no ☐	dk/u ☐	Describe:
Hospitalized?	yes ☐	no ☐	dk/u ☐	Describe:
Other physical problems or symptoms?	yes ☐	no ☐	dk/u ☐	Describe:
Being treated by another health care professional?	yes ☐	no ☐	dk/u ☐	For: Date of most recent physical exam:

Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.	
Medication:	Taken for:

WOMEN ONLY

Are you pregnant?	yes ☐	no ☐	dk/u ☐	If yes, how many months?
Are you nursing?	yes ☐	no ☐	dk/u ☐	
Are you anticipating becoming pregnant?	yes ☐	no ☐	dk/u ☐	
Onset of first menstrual period (relates to growth):				

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so please explain.

Bleeding disorders	yes ☐	no ☐	dk/u ☐	
Diabetes	yes ☐	no ☐	dk/u ☐	
Arthritis	yes ☐	no ☐	dk/u ☐	
Severe allergies	yes ☐	no ☐	dk/u ☐	
Unusual dental problems	yes ☐	no ☐	dk/u ☐	
Jaw size imbalance	yes ☐	no ☐	dk/u ☐	
Any other family medical conditions that we should know about?				

DENTAL HISTORY

Now or in the past have you had the following? If so, please explain.

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 ☐	
"Gum boils", frequent canker sores or cold sores?	yes ☐	no ☐	dk/u ☐	
Thumb, finger, or sucking habit?	yes ☐	no ☐	dk/u ☐	Until what age?
Abnormal swallowing habit?	yes ☐	no ☐	dk/u ☐	
Tongue thrusting?	yes ☐	no ☐	dk/u ☐	
History of speech problems?	yes ☐	no ☐	dk/u ☐	
Mouth breathing habit, snoring or difficulty breathing?	yes ☐	no ☐	dk/u ☐	
Tooth grinding or jaw clenching?	yes ☐	no ☐	dk/u ☐	
Any pain, clicking or locking 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 in chewing or jaw opening?	yes ☐	no ☐	dk/u ☐	
Have you ever been treated for "TMD" or "TMJ" problems?	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 ☐	
Any relatives with similar tooth or jaw relationships?	yes ☐	no ☐	dk/u ☐	
Any wisdom teeth problems?	yes ☐	no ☐	dk/u ☐	
Had periodontal (gum) treatment?	yes ☐	no ☐	dk/u ☐	
Had any serious trouble associated with any previous dental treatment?	yes ☐	no ☐	dk/u ☐	

Been under another dentist's care?	yes ☐	no ☐	dk/u ☐	Specialist: Other:
Ever had a prior orthodontic examination or treatment?	yes ☐	no ☐	dk/u ☐	
Would you object to wearing orthodontic appliances (braces) should they be indicated?	yes ☐	no ☐	dk/u ☐	
How often do you brush? How often do you 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 or record or medical/dental status, I will so inform this practice.

Patient (or guardian) signature: Date signed:

Dental staff member signature: Date signed:

MEDICAL HISTORY UPDATE OR CHANGES

Comments:

Patient (or guardian) signature: Date signed:

Dental staff member signature: Date signed:

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