Patient Medical History Form

Date:___/___/____

Patient's Name:______________________________ **Date of Birth:__________________**
Parents/Guardian (for minors):____________________ **General Dentist:__________________**

What are the main concerns that you would like orthodontics to accomplish: ______________________________

Has the patient ever been evaluated or had orthodontic treatment before?........Yes or No

Have there been any injuries to the face, mouth, teeth or chin?.........................Yes or No
Please explain:____

Has the patient ever had any pain / tenderness in his / her jaw joint (TMJ)?.... Yes or No

The patient's current dental health is: GOOD FAIR POOR

Have you been informed of any missing or extra permanent teeth?...........................Yes or No

Has the patient ever had any of the following medical / dental problems?

Yes or No Clenching / Grinding
Yes or No Lip Sucking / Biting
Yes or No Mouth Breather
Yes or No Nail Biting
Yes or No Speech Problems
Yes or No Thumb / Finger Sucking
Yes or No Tongue Thrust

The patient's current physical health is: GOOD FAIR POOR

Is the patient currently under the care of a physician?.......Yes or No
Please explain:____

For Adolescents: Has puberty begun? Yes or No Has menstruation begun? (Girls) Yes or No Date:_________

For Women: Are you pregnant? Yes or No Week #:_______

Please list all drugs that the patient is currently taking:______________________________
Please list all drugs / things that the patient is allergic to:______________________________

Has the patient ever has any of the following diseases or medical problems:

Yes or No Abnormal Bleeding
Yes or No ADD/ADHD
Yes or No Allergies to any Drugs
Yes or No Allergies to Latex
Yes or No Allergies to Metals
Yes or No Any Hospital Stays
Yes or No Artificial Bones/ Joints
Yes or No Artificial Valves
Yes or No Asthma / Arthritis
Yes or No Cancer
Yes or No Congenital Heart Defects
Yes or No Convulsions / Epilepsy
Yes or No Diabetes
Yes or No Handicaps / Disabilities
Yes or No Hearing Impairment
Yes or No Heart Murmur
Yes or No Heart Surgery
Yes or No Hemophilia
Yes or No Hepatitis
Yes or No HIV+ / AIDS
Yes or No Mitral Valve Prolapse
Yes or No Kidney / Liver problems
Yes or No Rheumatic/ Scarlet Fever
Yes or No Tuberculosis (TB)
Yes or No Taking Bisphosphenate medications

Please list any serious medical condition(s) that the patient has ever had:

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I understand that the information that I have given today is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services that may be needed during diagnosis and treatment with my informed consent.

Signature of Patient or Parent/Guardian: ____________________________ Date: ___/___/____