HEALTH HISTORY FORM

Link ORTHODONTICS

PATIENT'S INFORMATION

Patient's Name _____

Date of Birth _____ Gender _____ Age _____

MEDICAL HISTORY

Now or in the past, have you had:

☐ Yes ☐ No ☐ N/A Birth defects or hereditary problems?
☐ Yes ☐ No ☐ N/A Bone fractures, any major accidents?
☐ Yes ☐ No ☐ N/A Rheumatoid or arthritic conditions?
☐ Yes ☐ No ☐ N/A Endocrine or thyroid problems?
☐ Yes ☐ No ☐ N/A Kidney problems?
☐ Yes ☐ No ☐ N/A Diabetes?
☐ Yes ☐ No ☐ N/A Cancer, tumor, radiation treatment or chemotherapy?
☐ Yes ☐ No ☐ N/A Stomach ulcer or hyperacidity?
☐ Yes ☐ No ☐ N/A Polio, mononucleosis, tuberculosis, pneumonia?
☐ Yes ☐ No ☐ N/A Problems of the immune system?
☐ Yes ☐ No ☐ N/A AIDS or HIV positive?
☐ Yes ☐ No ☐ N/A Hepatitis, jaundice or liver problem?
☐ Yes ☐ No ☐ N/A Fainting spells, seizures, epilepsy or neurological problem?
☐ Yes ☐ No ☐ N/A Mental health disturbance or depression?
☐ Yes ☐ No ☐ N/A Vision, hearing, tasting or speech difficulties?
☐ Yes ☐ No ☐ N/A Loss of weight recently, poor appetite?
☐ Yes ☐ No ☐ N/A History of eating disorder (anorexia, bulimia)?
☐ Yes ☐ No ☐ N/A Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ Yes ☐ No ☐ N/A High or low blood pressure?
☐ Yes ☐ No ☐ N/A Chest pain, shortness of breath or swelling ankles?
☐ Yes ☐ No ☐ N/A Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects. heart murmur or rheumatic heart disease)?
☐ Yes ☐ No ☐ N/A Frequent headaches, colds or sore throats?
☐ Yes ☐ No ☐ N/A Eye, ear, nose or throat condition?
☐ Yes ☐ No ☐ N/A Hayfever, asthma, sinus trouble or hives?
☐ Yes ☐ No ☐ N/A Tonsil or adenoid conditions?
☐ Yes ☐ No ☐ N/A Osteoporosis?

Allergies or reactions to any of the following:

☐ Yes ☐ No ☐ N/A Local anesthetics (Novocaine or Lidocaine)
☐ Yes ☐ No ☐ N/A Aspirin
☐ Yes ☐ No ☐ N/A Ibuprofen (Motrin, Advil)
☐ Yes ☐ No ☐ N/A Penicillin or other antibiotics
☐ Yes ☐ No ☐ N/A Sulfa drugs
☐ Yes ☐ No ☐ N/A Codeine or other narcotics
☐ Yes ☐ No ☐ N/A Metals (jewelry, clothing snaps)
☐ Yes ☐ No ☐ N/A Latex (gloves, balloons)
☐ Yes ☐ No ☐ N/A Vinyl
☐ Yes ☐ No ☐ N/A Acrylic
☐ Yes ☐ No ☐ N/A Foods (specify)
☐ Yes ☐ No ☐ N/A Other substances (specify)
☐ Yes ☐ No ☐ N/A Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____

☐ Yes ☐ No ☐ N/A Do you currently have or ever had a substance abuse problem?
☐ Yes ☐ No ☐ N/A Do you chew or smoke tobacco?
☐ Yes ☐ No ☐ N/A Operations?
Describe: _____
☐ Yes ☐ No ☐ N/A Hospitalized?
Describe: _____
☐ Yes ☐ No ☐ N/A Other physical problems or symptoms?
Describe: _____
☐ Yes ☐ No ☐ N/A Being treated by another health care professional?
For: _____
Date of most recent physical exam?
_____

Do you have any other medical conditions that we should know about? _____

Female Patients

☐ Yes ☐ No ☐ N/A Are you pregnant?

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 _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past, have you had:

☐ Yes ☐ No ☐ N/A Permanent or "extra" (supernumerary) teeth removed?

☐ Yes ☐ No ☐ N/A Supernumerary (extra) or congenitally missing teeth?

☐ Yes ☐ No ☐ N/A Chipped or otherwise injured primary (baby) or permanent teeth?

☐ Yes ☐ No ☐ N/A Teeth sensitive to hot or cold; teeth throb or ache?

☐ Yes ☐ No ☐ N/A Jaw fractures, cysts or mouth infections?

☐ Yes ☐ No ☐ N/A "Dead teeth' or root canals treated?

☐ Yes ☐ No ☐ N/A Bleeding gums, bad taste or mouth odor?

☐ Yes ☐ No ☐ N/A Periodontal "gum problems"?

☐ Yes ☐ No ☐ N/A Food impaction between teeth?

☐ Yes ☐ No ☐ N/A "Gum boils", frequent canker sores or cold sores?

☐ Yes ☐ No ☐ N/A Thumb, finger, or sucking habit? Until what age?_____

☐ Yes ☐ No ☐ N/A Abnormal swallowing habit (tongue thrusting)?

☐ Yes ☐ No ☐ N/A History of speech problems?

☐ Yes ☐ No ☐ N/A Mouth breathing habit, snoring or difficulty in breathing?

☐ Yes ☐ No ☐ N/A Tooth grinding or jaw clenching?

☐ Yes ☐ No ☐ N/A Any pain, clicking or locking in jaw or ringing in the ears?

☐ Yes ☐ No ☐ N/A Any pain or soreness in the muscles of the face or around the ears?

☐ Yes ☐ No ☐ N/A Difficulty in chewing or jaw opening?

☐ Yes ☐ No ☐ N/A Have you ever been treated for "TMD" or "TMJ" problems?

☐ Yes ☐ No ☐ N/A Aware of loose, broken or missing restorations (fillings)?

☐ Yes ☐ No ☐ N/A Any teeth irritating cheek, lip, tongue or palate?

☐ Yes ☐ No ☐ N/A Concerned about spaced crooked or protruding teeth?

☐ Yes ☐ No ☐ N/A Aware or concerned about under or over developed jaw?

☐ Yes ☐ No ☐ N/A Any relative with similar tooth or jaw relationships?

☐ Yes ☐ No ☐ N/A Any wisdom tooth problems?

☐ Yes ☐ No ☐ N/A Had any serious trouble associated with any previous dental treatment?

☐ Yes ☐ No ☐ N/A Been under another dentist's care? Specialist _____

Other _____

☐ Yes ☐ No ☐ N/A Ever had a prior orthodontic examination or treatment? Orthodontist _____

☐ Yes ☐ No ☐ N/A Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush:_____ Floss: _____

What is your primary concern? How may we help you? _____

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.

Patient Signature: _____ Date: _____

Staff Member Signature: _____ Date: _____