



**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 Prefers To Be Called: \_\_\_\_\_

S.S.N./S.I.N.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone No.: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Address: \_\_\_\_\_

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

Attends School At: \_\_\_\_\_ Grade: \_\_\_\_\_ 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 birthweight \_\_\_\_\_ 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/pager: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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 from patient's): \_\_\_\_\_

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

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. : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ How many years? \_\_\_\_\_

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 you 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?

**MEDICAL HISTORY**

**Now or in the past, has the patient 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 or 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 behavioral problem?
- 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 Tires easily?
- yes  no  dk/u Chest pain, shortness of breath or swelling ankles?
- 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?

**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 \_\_\_\_\_

- 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? For: \_\_\_\_\_
- 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?  
 \_\_\_\_\_

# DENTAL HISTORY

## 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, jaw clenching clicking or locking?
- 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 patient 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? \_\_\_\_\_

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)

## MEDICAL HISTORY UPDATE OR CHANGES

Comments: \_\_\_\_\_

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)

## MEDICAL HISTORY UPDATE OR CHANGES

Comments: \_\_\_\_\_

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)

## MEDICAL HISTORY UPDATE OR CHANGES

Comments: \_\_\_\_\_

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Parent or Guardian)

Signed: \_\_\_\_\_ Date Signed \_\_\_\_\_  
(Dental Staff Member)