American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form For Patients Under 18

PATIENT

Date _____

Patient's Last name _____ First name _____ Middle initial ____

Prefers to be called _____ Hobbies, activities _____

Birth date:_____ What sex was the patient assigned on their birth certificate? ☐ Male ☐ Female

What is the patient's current gender identification? ☐ Male ☐ Female ☐ Other

What are the patient's preferred pronouns? _____

Social Security # _____

School _____ Grade ____ E-mail address(es)_____

Home address _____ City, State, Zip code_____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*) ☐ Parent 1/Guardian ☐ Parent 2/Guardian ☐ Parent 3/Guardian ☐ Parent 4/Guardian

☐ Other, if other, what is the relationship? _____

Parent 1/Guardian full name _____

Occupation _____ Email address _____

Address (*if different*) _____

Cell Phone (*if different*): _____ Home phone _____

Work phone _____

Parent 2/Guardian full name _____

Occupation _____ Email address _____

Address (*if different*): _____

Cell Phone (*if different*): _____ Home phone _____

Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen Name _____ City, State_____

Reason_____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her/their teeth _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age ____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FAMILY MEDICAL HISTORY

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

Bleeding disorders _____

Diabetes _____

Arthritis _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Other family medical conditions? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. 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. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY UPDATES

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____ Next appointment _____ Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____ Reason _____

Name _____ City, State _____ Reason _____

Your answers are for office records only and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, mark yes, no, or don't know/understand (dk/u).

PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Does the patient currently have (or ever had) a substance abuse problem? _____

Do you think that any of your child's activities affect his/her/their face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems _____

MEDICAL HISTORY

Now or in the past, has your child had:

☐ yes ☐ no ☐ dk/u Emotional, sensory or developmental issues?
☐ yes ☐ no ☐ dk/u Hereditary or developmental conditions?
☐ yes ☐ no ☐ dk/u Bone fractures, or major injuries?
☐ yes ☐ no ☐ dk/u Any injuries to face, head, neck?
☐ yes ☐ no ☐ dk/u Arthritis or joint problems?
☐ yes ☐ no ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no ☐ dk/u Endocrine or thyroid problems?
☐ yes ☐ no ☐ dk/u Diabetes or low sugar?
☐ yes ☐ no ☐ dk/u Kidney problems?
☐ yes ☐ no ☐ dk/u Immune system problems?
☐ yes ☐ no ☐ dk/u History of osteoporosis?
☐ yes ☐ no ☐ dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ yes ☐ no ☐ dk/u AIDS or HIV positive?
☐ yes ☐ no ☐ dk/u Hepatitis, jaundice or other liver problems?
☐ yes ☐ no ☐ dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no ☐ dk/u Seizures, fainting spells, neurologic problem?
☐ yes ☐ no ☐ dk/u Mental health disturbance or depression?
☐ yes ☐ no ☐ dk/u History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no ☐ dk/u Frequent headaches or migraines?
☐ yes ☐ no ☐ dk/u High or low blood pressure?
☐ yes ☐ no ☐ dk/u Excessive bleeding or bruising tendency, anemia?
☐ yes ☐ no ☐ dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
☐ yes ☐ no ☐ dk/u Heart defects, heart murmur, rheumatic heart disease?
☐ yes ☐ no ☐ dk/u Angina, arteriosclerosis, stroke or heart attack?
☐ yes ☐ no ☐ dk/u Skin disorder (other than common acne)?
☐ yes ☐ no ☐ dk/u Does your child eat a well-balanced diet?
☐ yes ☐ no ☐ dk/u Vision, hearing, or speech problems?
☐ yes ☐ no ☐ dk/u Frequent ear infections, colds, throat infections?
☐ yes ☐ no ☐ dk/u Asthma, sinus problems, hayfever?
☐ yes ☐ no ☐ dk/u Tonsil or adenoids removed?
☐ yes ☐ no ☐ dk/u Does your child frequently breathe through his/her mouth?
☐ yes ☐ no ☐ dk/u Has your child ever taken intravenous medication for bone disorders or cancer such as bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐ yes ☐ no ☐ dk/u Has your child ever taken oral medication for bone disorders such as bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) ?

MEDICAL HISTORY continued

Has your child had allergies or reactions to any of the following?

☐ yes ☐ no ☐ dk/u Latex (gloves, balloons)
☐ yes ☐ no ☐ dk/u Metals (jewelry, clothing snaps)
☐ yes ☐ no ☐ dk/u Acrylics
☐ yes ☐ no ☐ dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐ yes ☐ no ☐ dk/u Aspirin
☐ yes ☐ no ☐ dk/u Ibuprofen (Motrin, Advil)
☐ yes ☐ no ☐ dk/u Penicillin
☐ yes ☐ no ☐ dk/u Other antibiotics
☐ yes ☐ no ☐ dk/u Plant pollens
☐ yes ☐ no ☐ dk/u Animals
☐ yes ☐ no ☐ dk/u Foods
☐ yes ☐ no ☐ dk/u Other substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

☐ yes ☐ no ☐ dk/u Erupting teeth very early or very 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 injured primary or permanent teeth?
☐ yes ☐ no ☐ dk/u Any sensitive or sore teeth?
☐ yes ☐ no ☐ dk/u Any lost or broken fillings?
☐ yes ☐ no ☐ dk/u Jaw fractures, cysts, infections?
☐ yes ☐ no ☐ dk/u Any teeth treated with root canals or pulpotomies?
☐ yes ☐ no ☐ dk/u Frequent canker sores or cold sores?
☐ yes ☐ no ☐ dk/u History of speech problems or speech therapy?
☐ yes ☐ no ☐ dk/u Difficulty breathing through nose?
☐ yes ☐ no ☐ dk/u Mouth breathing habit or snoring at night?
☐ yes ☐ no ☐ dk/u History of speech problems?
☐ yes ☐ no ☐ dk/u Frequent habit of thumb/finger sucking?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of tongue thrust?
Current ___ Yes ___ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of fingernail biting?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Frequent habit of lip sucking?
Current ___ Yes ____ No Age stopped _____
☐ yes ☐ no ☐ dk/u Teeth causing irritation to lip, cheek or gums?
☐ yes ☐ no ☐ dk/u Tooth grinding or clenching?
☐ yes ☐ no ☐ dk/u Clicking, locking in jaw joints?
☐ yes ☐ no ☐ dk/u Soreness in jaw muscles or face muscles?
☐ yes ☐ no ☐ dk/u Has your child been treated for "TMJ" or "TMD" problems?
☐ yes ☐ no ☐ dk/u Any broken or missing fillings?
☐ yes ☐ no ☐ dk/u Any serious trouble associated with previous dental treatment?
☐ yes ☐ no ☐ dk/u Has your child ever been diagnosed with gum disease or pyorrhea?

How often does your child brush?_____
Floss?_____