

Patient History Form

Exam Date _____

Patient's Name _____

School/ Employer _____

Age _____ DOB _____ Sex _____

Grade /Position _____

Address _____

Phone _____

City _____ Zip Code _____

Hobbies _____

Home Phone _____

Musical Instrument Played _____

Height _____ Weight _____

Responsible Party's Information

Full Name _____ Marital Status _____

SS# _____ Relationship to Patient _____

Spouse's Full Name _____

Responsible Party's Address _____

Employer _____

Home Phone _____ Cell Phone _____

Email Address _____

Dental History

General Dentist _____ Phone _____ Date of Last Exam _____

Chief Orthodontic Complaint _____

Dental/Facial Trauma (Yes/ No) _____ Broken/Missing Teeth (Yes / No) _____

Jaw/Joint Problems (Yes/ No) Locking, clicking, grinding, popping (Circle as needed)

Habits (Yes/No) Thumb/ Finger Sucking, nail biting (Circle as needed)

Previous Orthodontic Treatment _____

Family members treated orthodontically _____

Is the patient self-conscious of his/ her teeth (Yes/ No) Very Moderate Unconcerned

Attitude toward wearing: Eager Resigned Indifferent Opposed

Does the patient brush his/ her teeth: Morning Noon After Dinner Before Bed?

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- Yes No Are you in good health?
- Yes No Have there been any changes in your general health within the past year?
Date of last physical exam _____
- Yes No Are you under the care of a physician? _____
If so, what is the condition being treated? _____
Name of physician _____
Address _____
- Yes No Have you had any serious illness, operation, or been hospitalized in the past 5 years?
If so, what was the illness or problem? _____
- Yes No Are you taking any medicine(s) including non-prescription medicine?
If so what medicine(s) are you taking? _____

Do you have or have you had any of the following diseases or problems?

- Yes No Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease.
- Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
- Yes No Do you have chest pain upon exertion?
- Yes No Are you ever short of breath after mild exercise or when lying down?
- Yes No Do your ankles swell?
- Yes No Do you have inborn heart defects?
- Yes No Do you have a cardiac pacemaker?
- Yes No Allergies _____ (especially metals)
- | | |
|--|---|
| Yes No Sinus Trouble | Yes No Low blood pressure |
| Yes No Fainting spells or seizures | Yes No Sexually transmitted disease |
| Yes No Persistent diarrhea or recent weight loss | Yes No Epilepsy or other neurological disease |
| Yes No Diabetes | Yes No Problems with mental health |
| Yes No Hepatitis, jaundice or liver disease | Yes No Cancer |
| Yes No AIDS or HIV infection | Yes No Problems with the immune system |
| Yes No Thyroid problems | Yes No Have you had abnormal bleeding? |
| Yes No Respiratory problems, emphysema, bronchitis | Yes No Have you ever had a blood transfusion? |
| Yes No Arthritis or painful swollen joints | Yes No Do you have any blood disorder such as anemia? |
| Yes No Kidney trouble | Yes No Persistent swollen glands in neck |
| Yes No Tuberculosis | Yes No Had treatment for a tumor or growth? |
| Yes No Persistent cough or cough that produces blood | Yes No Do you have any disease, condition, or problem not listed above that that you think I should know about? _____ |
| Yes No Asthma or hay fever | Yes No Stomach ulcer or hyperacidity |
- Women
Yes No Are you pregnant? _____
- Yes No Are you anticipating becoming pregnant? _____

Signature of Patient/ Parent

Signature of Doctor