Cupertino Ortho Care

Sophia I. Bulucea, DMD, MSD

Date ____________ Name ____________________________ Age ____ Sex ______

Family Dentist ______________ Address __________________________________

Referred by ____

Reason for seeking an orthodontic consultation _______________________________

Have any family members been treated in this office? ☐ Yes ☐ No

Has the patient had previous orthodontic treatment? ☐ Yes ☐ No

Do you go to the dentist regularly? ☐ Yes ☐ No

Have you had any recent dental treatment? ☐ Yes ☐ No

If so what? ____

Do you ever have feeling of dryness or burning in the mouth? ☐ Yes ☐ No

Dental and Temporomandibular Joint History

Has the patient ever been treated for TMJ (“Jaw joint”) problems? ☐ Yes ☐ No

Does the patient have?

1. difficulty in mouth opening? ☐ Yes ☐ No
2. pain or clicking in jaw joint? ☐ Yes ☐ No
3. pain on chewing, yawning or wide opening? ☐ Yes ☐ No
4. a bite that feels “uncomfortable” or “unusual”? ☐ Yes ☐ No
5. a jaw that “locks”, “gets stuck” or “goes out”? ☐ Yes ☐ No
6. noises in or from the jaw joints ☐ Yes ☐ No
7. frequent headaches or pain in front or behind the ears? ☐ Yes ☐ No
8. injury or blow to the head and neck region? ☐ Yes ☐ No

The following habits are of interest. List information as it pertains to this patient:

1. thumb/finger/lip sucking until _____ (age) ☐ Yes ☐ No
2. grinding or clenching of teeth ☐ Yes ☐ No
3. tongue thrusting or other functional problems ☐ Yes ☐ No

Continued

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Medical History

Physician's Name ______________________________ Address_____________________________

Are you under the care of a physician ☐ Yes ☐ No

If yes, for what reason? ____

Your current physical health is ☐ Good ☐ Fair ☐ Poor

Medications you are currently taking: ____

Are you allergic to latex products? ☐ Yes ☐ No

Do you have any other allergies? ☐ Yes ☐ No

If yes, please specify ____

Do you need antibiotic premedication before dental treatment? ☐ Yes ☐ No

Have you ever had or are now having any of the following:

Heart problems ☐ Yes ☐ No

(such as congenital heart defects, heart murmurs, artificial heart valves, rheumatic heart disease, mitral valve prolapse)

Artificial Joints ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No

Epilepsy ☐ Yes ☐ No

Liver disease ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Excessive bleeding ☐ Yes ☐ No

Previous Surgeries____

Other (describe below)

____

Signature: _____________________________ Relationship: _______________ Date: _________