Supplemental Health / Dental History for Orthodontics Evaluation

Date: _____

Patient's last name: _____

Patient's first name: _____

Reason for seeking an orthodontics evaluation: _____

Does your child play a musical instrument: _____

Describe any previous orthodontic treatment: _____

MEDICAL HISTORY

Now or in the past, has your child had:

Yes	No	DK/U	
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
☐	☐	☐	Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

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

Yes	No	DK/U	
☐	☐	☐	Local anesthetics (lidocaine etc)
☐	☐	☐	Latex
☐	☐	☐	Aspirin, Ibuprofen, Advil
☐	☐	☐	Metals (jewelry, clothing snaps), Acrylics
☐	☐	☐	Other substances

DENTAL HISTORY

Now or in the past, has your child had:

☐	☐	☐	Permanent or extra teeth removed?
☐	☐	☐	Chipped or injured baby or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Baby teeth removed that were not loose?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	Difficulty breathing though nose?
☐	☐	☐	Supernumerary (extra) or congenitally missing teeth?
☐	☐	☐	Has your child been treated for “TMJ” or “TMD” problems?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc?)
☐	☐	☐	Teeth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Has your child been treated for “TMJ” or “TMD” problems?
☐	☐	☐	Has your child ever been diagnosed with gum disease or pyorrhea?
☐	☐	☐	Any serious trouble associated with previous dental treatment?

PATIENT HEALTH INFORMATION

Does your child take antibiotic pre-medications before any dental procedures? _____

FAMILY MEDICAL HISTORY

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

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 OR CHANGES

Changes _____

Parent / Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent / Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____