willow lake
ORTHODONTICS

Medical and Dental History

Patients Over 18 years of Age

Date _____

Patient's Last Name_____ First_____ Middle _____
Birthdate_____ Age_____ M or F_____ Home phone_____
Patient's Address: Street_____
City_____ State_____ Zip _____
Patient's Place of employment_____
Patient's work phone_____ Patient's cellular phone _____
Email Address _____
Name of Contact (in case of emergency) _____ Phone_____
Contact's Relationship to Patient _____
General Dentist _____ Date of last dental exam _____
Dentist's Address _____
Whom May We Thank For the Referral _____

Please answer **all** the questions by filling in the blank spaces or circling **yes**, **no**, or **don't 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.

Yes No DK/U Are you in good health?
Yes No DK/U Have there been any change in your general health within the past year?
Yes No DK/U Are you currently under the care of a physician or currently being treated for any problem?
If so please indicate _____
Yes No DK/U List any current medications, including weight-altering drugs_____
_____
Yes No DK/U List any allergies, including those to medications _____

FEMALE PATIENTS:
Yes No DK/U Are you pregnant?
Yes No DK/U Are you taking birth control pills?
Yes No DK/U Are you anticipating becoming pregnant?

MEDICAL HISTORY

Yes No DK/U Birth defects or heredity 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 or been treated for a tumor?
Yes No DK/U Stomach ulcer or hyperacidity?
Yes No DK/U Polio, mono, tuberculosis, pneumonia?
Yes No DK/U Loss of weight recently or poor appetite?
Yes No DK/U High or low blood pressure?
Yes No DK/U Eye, ear, nose, throat condition?
Yes No DK/U Allergies or drug reactions?
Yes No DK/U Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, or rheumatic heart)?

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 problems?
Yes No DK/U Fainting spells, seizures, epilepsy or neurological problems?
Yes No DK/U Operations? (surgical procedures?)
Yes No DK/U Mental health or behavioral problems?
Yes No DK/U Vision, hearing, tasting or speech problem?
Yes No DK/U Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Yes No DK/U Chest pain, shortness of breath or swollen ankles?
Yes No DK/U Hayfever, asthma, sinus trouble, hives?
Yes No DK/U Tonsil or adenoid condition?
Yes No DK/U Frequent headaches, colds, or sore throat?

Other miscellaneous information you would like the doctor to know: _____
_____

DENTAL HISTORY

Yes	No	DK/U	Permanent or extra teeth removed?
Yes	No	DK/U	Chipped or otherwise injured permanent teeth?
Yes	No	DK/U	"Dead teeth" or root canals treated?
Yes	No	DK/U	Periodontal or gum problems?
Yes	No	DK/U	"Gum boils", frequent canker sores, cold sores?
Yes	No	DK/U	Abnormal swallowing habit, tongue thrusting?
Yes	No	DK/U	Tooth grinding, jaw clenching, clicking, locking?
Yes	No	DK/U	Pain or soreness in face muscles?
Yes	No	DK/U	Difficulty in chewing or jaw opening?
Yes	No	DK/U	Concerned about space, crooked, or protruding teeth?
Yes	No	DK/U	Any wisdom teeth problems?
Yes	No	DK/U	Teeth sensitive to hot or cold?
Yes	No	DK/U	Jaw fractures, cysts, mouth infections?
Yes	No	DK/U	Bleeding gums, bad taste, mouth odor
Yes	No	DK/U	Food impaction between teeth?
Yes	No	DK/U	Any loose, broken, or missing fillings?
Yes	No	DK/U	Thumb, finger, sucking habit?
Yes	No	DK/U	Any prior orthodontic exam or treatment?
Yes	No	DK/U	Mouth breathing, snoring, difficulty in breathing?
Yes	No	DK/U	Any pain in the jaw or ringing in ears?
Yes	No	DK/U	Concerned about under or over developed jaw?
Yes	No	DK/U	Any relative with similar tooth or jaw relationship?

What's are your primary orthodontic concern? _____

Realizing that successful treatment depends greatly on patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

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.

_____

Signature of patient Date

_____

Orthodontist Date

Medical History Update or Changes:

Date Comments Signature

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