willow lake
ORTHODONTICS

Medical and Dental History

Patients Under 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 school_____ Grade_____

Parent/Guardian's Name_____
Parent/Guardian's Address: Street_____
City_____ State_____ Zip_____
Phone_____ Cellular/ Mobile Phone_____
Parent's Place of Employment _____
Parent's Email Address _____
Parent is: ___Single ___Married ___Separated ___Divorced ___Widowed
Spouse/Other Parent (if applicable) _____ Phone _____
Spouse/Other Parent Address (if applicable): Street _____
City_____ State_____ Zip_____
Father's Height_____ Mother's Height_____
Family 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.

Yes No DK/U Is the patient in good health?
Yes No DK/U Have there been any change in the patient's general health within the past year?
Yes No DK/U Is the patient 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 _____
Yes No DK/U List any allergies, including those to medications _____

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 Eye, ear, nose, throat condition?
Yes No DK/U Hepatitis, jaundice, or liver problems?
Yes No DK/U High or low blood pressure?
Yes No DK/U Chest pain, shortness of breath or swollen ankles?
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 Fainting spells, seizures, epilepsy or neurological problems?
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 Allergies or drug reactions
Yes No DK/U Hayfever, asthma, sinus trouble, hives?
Yes No DK/U Tonsil or adenoid condition?
Yes No DK/U Operations? (surgical procedures?)
Yes No DK/U Frequent headaches, colds, or sore throat?

DENTAL HISTORY

Yes No DK/U Started teething very early or late?
Yes No DK/U Permanent or baby teeth removed?
Yes No DK/U Chipped or injured baby or permanent teeth?
Yes No DK/U "Dead teeth" or root canals treated?
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 Difficulty in chewing or jaw opening?
Yes No DK/U Any wisdom teeth problems?
Yes No DK/U Concerned about space, crooked, or protruding teeth?
Yes No DK/U Onset of puberty? Date_____

Yes No DK/U Food impaction between teeth?
Yes No DK/U Extra or congenitally missing teeth?
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 Pain or soreness in face muscles?
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 Any relative with similar tooth or jaw relationship?
Yes No DK/U Concerned about under or over developed jaw?

What's the patient's primary concern or chief complaint? _____

I have read and understand the above questions. I will **not** hold my orthodontist or any member of 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 parent or guardian Date

_____ _____
Orthodontist Date

Medical History Update or Changes:

Date Comments Signature

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