



ORTHODONTICS

JOE BRYANT, D.D.S., Ltd.

Confidential

**AMERICAN ASSOCIATION OF ORTHODONTISTS
MEDICAL DENTAL HISTORY FORM**

DATE _____

Patient's Last Name _____ First _____ Middle _____

Present Weight _____ Height _____

Musical Instruments Played _____

Favorite Sports or Hobbies _____

Patient's School (if Child) _____ Grade _____

For the following questions circle yes, no, or don't know/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 Does patient follow directions?

yes no dk/u Endocrine or thyroid problems?

yes no dk/u Does patient brush his/her teeth conscientiously?

yes no dk/u Kidney problems?

yes no dk/u Does patient have learning disabilities or need extra help with instructions?

yes no dk/u Diabetes?

yes no dk/u Is patient sensitive, self-conscious?

yes no dk/u Cancer or been treated for tumor?

yes no dk/u Stomach ulcer or hyperacidity?

yes no dk/u Polio, mono, tuberculosis, pneumonia?

MEDICAL HISTORY _____

yes no dk/u Problems of the immune system?

yes no dk/u Birth defects or heredity problems?

yes no dk/u AIDS or HIV positive?

yes no dk/u Bone fractures, any major accidents?

yes no dk/u Hepatitis, jaundice or liver problem?

yes no dk/u Rheumatoid or arthritic conditions?

yes no dk/u Fainting spells, seizures, epilepsy or neurologic problem?

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yes no dk/u Mental health or behavioral problems?

yes no dk/u Vision, hearing, tasting problems?

es no dk/u Loss of weight recently, poor appetite?

yes no dk/u Excessive bleeding, bruise easily, bleeding disorders?

yes no dk/u High or low blood pressure?

yes no dk/u Tires easily?

yes no dk/u Chest pain, shortness of breath or swelling ankles?

yes no dk/u Cardiovascular problems (heart trouble, heart attack, coronary insufficiency, stroke, inborn heart defects, or rheumatic heart disease?)

yes no dk/u Skin disorder?

yes no dk/u Any pain in jaw or ringing in ears?

es no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?

yes no dk/u Difficulty encountered in chewing or jaw opening?

yes no dk/u Aware of loose, broken or missing fillings?

yes no dk/u Any teeth irritating cheek, lip, tongue, palate?

yes no dk/u Aware or concerned about under or over developed jaw?

yes no dk/u Any relative with similar tooth or jaw relationships?

yes no dk/u Any wisdom tooth problems?

yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?

yes no dk/u Onset of puberty (approx. date_____)

yes no dk/u Has patient ever had a prior orthodontic exam or treatment?

yes no dk/u Has patient ever had periodontal (gum) treatment?

yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

DENTAL HISTORY_____

yes no dk/u Permanent or extra (supernumerary) tooth removed?

yes no dk/u Congenitally missing teeth?

yes no dk/u Teeth sensitive to hot/cold, toothaches?

yes no dk/u Jaw fractures?

yes no dk/u Periodontal "gum" problems?

yes no dk/u Thumb, finger, sucking habits?

yes no dk/u Tongue thrusting?

yes no dk/u Speech problems?

yes no dk/u Mouth breathing habit, snoring, breathing difficulty?

yes no dk/u Tooth grinding, jaw clenching, clicking, locking?

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