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DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS

Medical History Form

Please complete the following:

PATIENT GENERAL INFORMATION

☐ MASTER ☐ MR. ☐ MRS. ☐ MISS

Last _____ First _____ Middle _____ Birthdate _____

Address _____ City _____ Postal Code _____ Telephone _____

If less than one year, previous address: _____

Business Address: _____
Employer

Address _____ City _____ Postal Code _____ Telephone _____

Marital Status: _____ Name of Spouse: _____

If patient is a minor, who is legally responsible? _____
Name

Address _____ City _____ Postal Code _____ Telephone _____

By whom were you referred? _____ When?: _____

INSURANCE INFORMATION

If you have have any type of dental insurance which covers orthodontics, please complete the following:
If not, please check this box ☐

Plan 1:

Name of Insurance Company: _____ Group No. _____

Employee: _____ Employee Social Insurance Number: _____

Patient: _____ Relationship To Employee: _____ Patient's Birthdate: _____

Employer: _____

Address _____ City _____ Postal Code _____ Telephone _____

Has the patient had previous dental care under this plan? _____

Is the patient covered by another plan? _____ If so, please complete the next section.

Plan 2:

Name of Insurance Company: _____ Group No. _____

Employee: _____ Employee Social Insurance Number: _____

Patient: _____ Relationship To Employee: _____ Patient's Birthdate: _____

Employer: _____

Address _____ City _____ Postal Code _____ Telephone _____

Has the patient had previous dental care under this plan? _____

MEDICAL HISTORY

Family Physician: _____
Name

_____ _____ _____ _____
Address City Postal Code Telephone

Additional Physician: _____
Name

_____ _____ _____ _____
Address City Postal Code Telephone

Height: _____ Weight: _____ Age: _____ Date of last complete medical examination: _____

Please check YES or NO. If YES, please fill in details

☐ Yes ☐ No Do you have a current medical problem? What? _____
☐ Yes ☐ No Do you have heart trouble? What Kind? _____
☐ Yes ☐ No Have you had rheumatic fever? When? _____
☐ Yes ☐ No Do you have high or low blood pressure? Is it controlled? _____
☐ Yes ☐ No Have you had pains in the chest or shortness of breath? _____
☐ Yes ☐ No Do your ankles swell? _____
☐ Yes ☐ No Has your physician ever told you that your anemic? _____
☐ Yes ☐ No Have you ever had a stroke? When? _____
☐ Yes ☐ No Have you ever had diabetes? How is it controlled? _____
☐ Yes ☐ No Are you subject to fainting or dizziness? When? _____
☐ Yes ☐ No Do you have headaches? How often? _____
☐ Yes ☐ No Do you have problems with insomnia? How often? _____
☐ Yes ☐ No Do you have a nervous disorder? How is it controlled? _____
☐ Yes ☐ No Do you take tranquilizers or sedatives? How often? _____
☐ Yes ☐ No Do you take aspirin? How often? _____
☐ Yes ☐ No Are you allergic to any medication? What? _____
☐ Yes ☐ No Have you been advised not to take any medication? What? _____
☐ Yes ☐ No Do you have asthma or hay fever? How is it controlled? _____
☐ Yes ☐ No Have you ever had tuberculosis? _____
☐ Yes ☐ No Have you ever had infectious hepatitis? When? _____
☐ Yes ☐ No Do you have arthritis? How is it controlled? _____
☐ Yes ☐ No Have you ever had a tumor or cancer? How was it treated? _____
☐ Yes ☐ No Have you had any operations? What kind? _____
☐ Yes ☐ No Have you ever been involved in a serious accident? _____
☐ Yes ☐ No Are you taking any medication? Please list:

Taking: _____ For: _____
Taking: _____ For: _____
Taking: _____ For: _____
Taking: _____ For: _____

☐ Yes ☐ No Have you gained or lost weight within the last year? How much? _____
☐ Yes ☐ No Do you become fatigued easily? At what time of day? _____
☐ Yes ☐ No Is your diet medically supervised? For what purpose? _____

FOR WOMEN

☐ Yes ☐ No Are you pregnant? Expected delivery date? _____
☐ Yes ☐ No Have you reached menopause? If so, are you taking supportive medication? _____

DENTAL HISTORY

Family Dentist: _____ Period of treatment: _____
Name Date

_____ _____ _____ _____
Address City Postal Code Telephone

Other Dentist: _____ Period of treatment: _____
Name Date

_____ _____ _____ _____
Address City Postal Code Telephone

Date of last dental visit: _____ Date of last full-mouth X-ray: _____

Date of last complete dental examination: _____ What is your immediate dental concern: _____

Have you seen an orthodontist: _____ If so, when? _____

Please check YES or NO. If YES, please fill in details

☐ Yes ☐ No Have you ever experienced any unfavorable reaction to dentistry?
What? _____

☐ Yes ☐ No Have you lost any teeth? From what cause? _____

☐ Yes ☐ No Have you ever had orthodontic treatment? When? _____

☐ Yes ☐ No Do you have any growths or swellings in your mouth? How long have they existed? _____

☐ Yes ☐ No Do you have any difficulty in swallowing? _____

☐ Yes ☐ No Do your gums bleed when brushing your teeth? _____

☐ Yes ☐ No Do you avoid brushing any part of your mouth? Why? _____

☐ Yes ☐ No Have you been told you have pyorrhea? When? _____

☐ Yes ☐ No Is any part of your mouth sensitive to temperature, pressure food, or drink? _____

☐ Yes ☐ No Do you have a burning sensation in your mouth? _____

☐ Yes ☐ No Have you ever had a bad reaction to dental anesthetic? When? _____

☐ Yes ☐ No Does food catch between your teeth? _____

☐ Yes ☐ No Do you have any pain or soreness around your eyes, ears or other parts of your face?
When? _____

☐ Yes ☐ No Are you aware of stiff neck muscles? How often? _____

☐ Yes ☐ No Do you ever awaken with an awareness of your teeth or jaws? How often? _____

☐ Yes ☐ No Are you aware of clenching your teeth during the daytime hours? How often? _____

☐ Yes ☐ No Have you ever been told you grind your teeth during sleep? How often? _____

☐ Yes ☐ No Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

☐ Yes ☐ No Do you have difficulty in opening your mouth wide? _____

☐ Yes ☐ No Do you have “tension” headaches? How often? _____

☐ Yes ☐ No Do you have an unpleasant taste or odor in your mouth? _____

☐ Yes ☐ No Are you satisfied with your teeth and appearance? _____

☐ Yes ☐ No Do any members of your family including your parents wear dentures? _____

☐ Yes ☐ No Are you willing to wear braces if they are necessary to restore your good dental health? _____

SEE NEXT PAGE FOR ANY ADDITIONAL NOTATIONS.

I hereby state that I have truthfully to the best of my ability answered all the above questions.

Signature: _____ Date: _____

Please use this space for any necessary explanations which may assist us in the proper diagnosis of any problems you may have.