ADVANCE ORTHODONTICS
Medical and Dental History

Your answers to the following questions are extremely important for diagnostic purposes.Thank you for your care in answering accurately.

Patient's Name:_____ Date:_____

Medical History

Do you have or have you ever had any of the following? **Circle all that apply.**

1. prosthetic heart valve
2. infective endocarditis
3. congenital heart disease (CHD)
    a. unrepaired cyanotic CHD, including palliative shunts and conduits
    b. completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention
    c. repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device
4. heart transplant and subsequent cardiac valvulopathy
5. hypertension (high blood pressure)
6. joint replacement
7. GERD / acid reflux
8. eating disorder (e.g. anorexia, bulimia)
9. diabetes
10. convulsions
11. HIV or AIDS
12. hemophilia / prolonged bleeding or other bleeding disorder
13. hepatitis
14. radiation or chemotherapy for tumors or cancer
15. osteoporosis
16. glaucoma
17. liver disease or disorder
18. kidney disease or disorder
19. head or neck injuries/operations

Do you smoke or use smokeless tobacco? If so, what product(s)?

List any health problem, illness, or disorder not mentioned above:

Within the past year, have you received treatment from a medical professional (physician, chiropractor, podiatrist, etc.)? If so, please give reason.

List all medications (prescription, non-prescription, herbal, supplements, etc.) which you are currently taking:

List any drug allergies or adverse drug reactions:

List allergies or adverse reactions to other substances or materials (e.g. latex):

Dental History

General:Circle all that apply: I…

1. have not been to a dentist in the last 12 months
2. have a close relative with similar arrangement of teeth or appearance of jaws
3. have had orthodontic treatment before

Approximate month and year of last dental checkup: _____

Who first noticed the need for orthodontic treatment? (circle one): self / parent / family / dentist / other

My attitude toward orthodontic treatment is (circle one): eagerness / willingness / complacency / resignation / antagonism

I am aware that orthodontic appointments will probably periodically infringe on my work/school schedule (circle one): yes / no

Habits: Circle all that apply: I…

1. currently or previously suck finger, thumb, lip, or tongue
2. bite my lips, tongue, fingernails, pencils, or other objects

Breathing: Circle all that apply: I…

1. have been told I snore while sleeping
2. have been diagnosed with sleep apnea
3. have had tonsillitis
4. have had my tonsils and/or adenoids removed
5. have asthma
6. have hay fever
7. breathe through my mouth most of the time

***VERY IMPORTANT*The reason(s) I am seeking orthodontic treatment is/are (i.e. my main concern):**

Detail any aspects of your facial features other than your teeth about which you are concerned (e.g. nose, chin, jaw line, etc.):

The single factor that is MOST important to me about my orthodontic treatment is… (circle one):
Quality results / Payment terms / Fast results / Convenience / How I look during treatment / Comfort during treatment

The factor that is SECOND most important to me about my orthodontic treatment is… (circle one):
Quality results / Payment terms / Fast results / Convenience / How I look during treatment / Comfort during treatment

The factor that is THIRD most important to me about my orthodontic treatment is… (circle one):
Quality results / Payment terms / Fast results / Convenience / How I look during treatment / Comfort during treatment

Children/Teens Only

Cooperation with primary care dentist has been (circle one): excellent / good / fair / poor

<girls only> She has started her period (circle one): yes / no approximate month & year of first cycle: _____

<boys only> He has started shaving and/or his voice has changed (circle one): yes / no If yes, circle which one(s).

Patient has recently experienced a rapid increase in height (circle one): yes / no

Name, age, and relation of any other family member who has received orthodontic treatment:

Signature **Printed Name** **Date**

Date: _____ Initials: _____ ← Updates → Date: _____ Initials: _____