Medical and Dental History for Patients Under 18 Years of Age

Patients Last Name:________________First name:________________
Middle initial_____Prefers to be called:___________
Date of birth:____________Age:________Gender:____________
Address:____City:__________
State_______Zip:________
Phone #:(home)_______________ Patients mobile:____________________
School:__________________________Grade:______
Sports/hobbies/interest:______________________
Any family treated here?________________________________
**Mother's name(or guardian):___________________________
Job title and employer:________________________
**Father's name:_____________________________________
Job title and employer:________________________
Who will bring patient to his/her appointments?
Name:_____________Mobile:__________Email:________________
**Who is financially responsible for this patient's account?
Last name:_______________First:__________________
Address (if different):____
City:___________________State:____________Zip:____________
Phone #:_____________________________
Employer:____Job
Title:______________________________
How did you hear about our
office?____
General dentist's name:_____________________City:_________________State:____
Date of patients last cleaning____________________________
Frequency of Cleanings: 3 months 4 months 6 months
Physician's name:_______________________________City:____________State:____

For the following questions, please mark yes (Y) or no (N). These answers are for office records only and are confidential. A thorough medical history is necessary for a proper orthodontic evaluation.

MEDICAL HISTORY **Now or in the past has the patient had:**

Y N Learning disabilities or need extra help with instructions?
Y N ADD or ADHD?
Y N Birth defects or hereditary problems?

Y N Was the patient adopted?
Y N Rheumatoid or arthritic conditions?
Y N Endocrine or thyroid problems?
Y N Diabetes?
Y N Cancer, tumor, radiation treatments, or chemotherapy?
Y N Acid reflux?
Y N Tuberculosis, polio, mononucleosis, or pneumonia?
Y N Problems of the immune system?
Y N HIV or AIDS?
Y N Hepatitis, jaundice, or liver problems?
Y N Seizures, Epilepsy, Fainting spells, or neurological problems?
Y N Mental health disturbance or depression?
Y N Vision, hearing, taste, or speech difficulties?
Y N History of eating disorder, anorexia or bulimia?
Y N Excessive bleeding or bruising tendency, anemia, or bleeding disorder?
Y N High or low blood pressure?
Y N Cardiovascular problems such as shortness of breath, angina, heart attack?
Y N Heart murmur, rheumatic fever, inborn heart defect, artificial heart valves?
Y N Allergies or asthma?
Y N Ear, nose, throat, tonsil or adenoid conditions?

Allergies or reactions to any of the following:

Y N Aspirin or Ibuprofen?
Y N Penicillin or other antibiotic?
Y N Codeine or other narcotics?
Y N Metals?
Y N Latex?
Y N Other
substances:____

Please list any medications, nutrient supplements, herbal medications, or non-prescription medicine the patient is currently taking:____

Y N Does the patient currently have or ever had a substance abuse problem?
Y N Does the patient chew or smoke tobacco?
Y N Please list any operations or
hospitalizations:____
Y N Being treated by another health care professional?
For____

For Girls Only:

Y N Has menstruation begun? When?______________________
Y N Is the patient pregnant?

DENTAL HISTORY Now or in the past has the patient had:

Y N Extra or supernumerary teeth?
Y N Congenitally missing teeth or any permanent teeth removed?

Y N Early loss of baby teeth due to decay or trauma?
Y N Trauma or injury to baby or permanent teeth?
Y N Jaw fractures, cysts, or mouth infections?
Y N Periodontal or gum problems?
Y N Thumb or finger sucking habit? Until what age?____________
Y N Tongue thrusting?
Y N History of speech problems?
Y N Mouth breathing habit?
Y N Tooth grinding, jaw clenching, clicking or locking, or other problems of the TMJ?
Y N Any pain in the jaw or face, ringing in the ears, or severe headaches?
Y N Frequent canker sores or cold sores?
Y Nany relative with similar tooth or jaw relationships?
Y N Any relative with jaw size imbalance?
Y N Ever had prior orthodontic examination or treatment?
Y N Is there anything you would like to discuss with the doctor in private?

I have read and understand the above questions. I will not hold Seymour Orthodontics 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 inform this practice.

Signed:____
Date:__________________
(Parent/Guardian)

Signed:____
Date:__________________
(Dental Staff member)

MEDICAL HISTORY UPDATE OR CHANGES
COMMENTS:____

Signed:____
Date:__________________