Member
Canadian Association of
Orthodontists

Canadian Association of Orthodontists
MEDICAL DENTAL HISTORY FORM

Date: _____

Patient's Last Name_____First_____Middle_____

Birthdate_____Age_____Sex_____Home Phone Number_____

Patient's Address _____Contact Email_____

_____Postal Code _____

Occupation _____ Business Phone #__ _____Cell Phone No._____

Name of emergency contact_____Phone #_____

CHILD PATIENT:

Mother's Name_____Address_____

Phone # (home)_____(work) _____(cell) _____

Father's Name_____ Address _____

Phone # (home)_____(work) _____(cell) _____

Patient's school_____ Grade_____

Whom may we thank for referring you to our office?_____

Name of Patient's Dentist_____

Name of Physician _____

Other family members treated _____

Musical instrument played _____

Favourite Sports & Hobbies_____

General Dental Insurance coverage yes_____ no_____

Orthodontic Insurance coverage yes_____ no_____

Please answer the medical and dental questions on the reverse side of this form. For each of the following questions circle one answer - 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.

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?

yes no dk/u Any major accidents to your mouth, lips or cheeks?

yes no dk/u Rheumatoid or arthritic conditions?

yes no dk/u Diabetes?

yes no dk/u Problems of the immune system?

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

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

yes no dk/u Mental health or behavioral problem?

yes no dk/u High or low blood pressure?

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

yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, or rheumatic heart?

yes no dk/u Are you in good health?

yes no dk/u Do you have a normal and good diet?

yes no dk/u Eye, ear, nose, throat condition?

yes no dk/u Hay fever, asthma, sinus trouble, hives?

yes no dk/u Tonsil or adenoid conditions?

yes no dk/u Allergies or drug reactions?

yes no dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them.

_____

yes no dk/u Hospitalized for_____

yes no dk/u Other physical problems or symptoms?

yes no dk/u Being treated by another health care professional?

For_____

Date of most recent physical exam?_____

DENTAL HISTORY

yes no dk/u Chipped or otherwise injured primary (baby) or permanent tooth?

yes no dk/u Periodontal 'Gum Problems'?

yes no dk/u Thumb, linger, sucking habit? Until _____

yes no dk/u History of speech problems?

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

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

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

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

yes no dk/u Concerned about spaced, crooked, protruding teeth?

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 Has patient ever had a prior orthodontic examination or treatment? Date/ type of treatment _____

_____

yes no dk/u Has patient recently been under another dentist's care?

Specialist _____

Other _____

Date of most recent dental examination_____

How often does patient brush _____floss_____

What is the patient's (or parent's) primary concern? - Why are you Here?

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps, problems that might be encountered during treatment?

_____

I have read and understand the above questions. If there are any changes later to this history record or medical/dental status I will inform this practice.

_____

Signature of parent or guardian Date

Doctor's Notes - Medical History Update or Changes:

_____Molar class_____ Canine class_____

_____OB_____ OJ_____

_____Crowding_____ Spacing_____

_____Crossbite: posterior_____ anterior_____

_____TMJ_____ Airway_____

_____smile line_____ gummy smile_____

_____Occlusal cant_____ Impacted teeth_____