HEALTH HISTORY

What is your primary orthodontic concern?_____

MEDICAL HISTORY

Y N Is the patient in excellent health?
Y N Has there been a change in the patient's general health in the last year?
Y N Patient's last physical exam was_____(month/year).
Y N Has the patient had a serious illness/hospitalization in the past five years?

Does the patient have a history of allergies or drug reactions to:
Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Aspirin, Ibuprofen, Tylenol
Y N Local anesthetics
Y N Codeine or any other narcotics

Does the patient have any of the following conditions?
Y N Respiratory problems or emphysema
Y N Asthma or hay fever
Y N Sinus problems/condition
Y N Persistently swollen glands in the neck area
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice, or liver disease
Y N AIDS, or HIV infection
Y N Sexually transmitted disease
Y N Substance abuse problem (past/present)
Y N Mental health problems or nervous disorders
Y N Fainting spells or seizures
Y N Epilepsy or other neurological disease
Y N Blood disorders, such as anemia, hemophilia
Y N Abnormal bleeding, history of blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, heart attach, angina, hypertension, arteriosclerosis, stroke)?
Y N Damaged/artificial heart valves, heart murmur, or rheumatic heart disease?
Y N Arthritis/joint problems or artificial joints/limbs?
Y N Does the patient require pre-medication for dental visits?
Y N Birth defects
Y N Kidney problems or history of renal failure?
Y N Tuberculosis
Y N Bone fractures or trauma to the face and/or jaw?
Y N Vision, hearing or speech problems?
Y N Persistent cough?
Y N Frequent colds or sore throat?
Y N Frequent headaches or history of migraine?
Y N Stomach ulcer or hyperacidity?
Y N History of tumor (cancerous or benign)?
Y N History of radiation or chemo therapy?
Y N If the patient is female, is there any chance you are pregnant?
Y N Does the patient have any disease, condition, or health problem not listed above that you think we should be aware of?

_____

DENTAL HISTORY

Please list the date of last dental exam _____ (month, year).

Have you ever experienced/had any of the following conditions?

Y N Jaw fracture, oral cyst, mouth infections?
Y N Bleeding gums or bad taste/strong mouth odor (halitosis)?
Y N Problems with food trapped between teeth?
Y N Frequent canker or cold sores?
Y N Mouth breathing habit or problem snoring?
Y N Abnormal/difficulty swallowing or tongue thrust?
Y N History of missing or supernumerary (extra) teeth?
Y N Extraction (removal) of a permanent tooth?
Y N Teeth that irritate the tongue, cheek, lip, etc.?
Y N Previous periodontal (gum) treatment?
Y N Thumb or finger sucking habit as a child?
Y N Loose or shifting teeth?
Y N Incomplete dental restorations/work at this time?
Y N Has the patient had an orthodontic evaluation?
Y N Has the patient had orthodontic treatment in the past?
_____
Y N Has another family member received orthodontic care in the past?
if so, whom?_____

TREATMENT OPTIONS

Invisalign

Braces

Why are you interested in an orthodontic evaluation for yourself or your child_____
What would you like to change about your/your child's smile?
_____
What is most important thing to you when considering orthodontic treatment?_____

Do you prefer Invisalign or Braces?_____

TMJ HISTORY (Temporomandibular Joint)

Y N Has the patient had a TMJ screening?
Y N Does the patient have a history TMJ joint (jaw joint) problems?
Y N Does the patient grind his/her teeth?
Y N Does his/her bite feel uncomfortable or unusual?
Y N Does the patient clench his/her teeth?
Y N Has the patients jaw ever locked?
Y N Does the patient have pain in his/her TMJ joint(jaw joint)?
Y N Does the patient experience soreness in the muscles of his/her face or around ears?
Y N Does the patient notice clicking or popping in opening his/her mouth?
Y N Does the patient experience difficulty chewing?

I certify that I have read and understand the questions stated above. In addition, I acknowledge that I have completed this form to the best of my knowledge, and that I have answered the questions to my satisfaction, I will not hold Dunn Orthodontics, Dr. Dunn, or any members of his staff responsible for any errors or omissions that I may have made while completing this form. I will inform this office of any change in medical or dental health/status.

_____
Signature of Patient/Parent/Guardian Date