

Office of Dr. Charles Harrington

CONFIDENTIAL

Medical Dental History Form for Patients

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Social Security # _____

Sex: Male Female Email address(es) _____

School (if child) _____ Grade _____

Home Address _____ City, State, Zip Code _____

Home phone () _____ - _____ Cell phone () _____ - _____

PARENT/GUARDIAN-(If patient is under 18)

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*):

Mother Father Stepmother Stepfather Grandparent(s) Other _____

Father's full name _____

Title: Mr. Dr. Other _____

Occupation _____ Email Address _____

Address (*if different*) _____

Home phone (*if different*) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

Mother's full name _____

Title: Mrs. Ms. Dr. Other _____

Occupation _____ Email Address _____

Address (*if different*) _____

Home phone (*if different*) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

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DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____

Next appointment _____

Other Dentists/dental specialists now being seen: Name _____

Address _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____

What concerns your child (if patient is under 18) about his/her teeth?

How do you feel about orthodontic treatment? _____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations _____

Do you play a musical instrument? _____

Brothers/sisters name _____ Age _____ Had orthodontic treatment? Yes No

If yes, where? _____

Brother/sister name _____ Age _____ Had orthodontic treatment? Yes No

If yes, where? _____

Brother/sister name _____ Age _____ Had orthodontic treatment? Yes No

If yes, where? _____

Brother/sister name _____ Age _____ Had orthodontic treatment? Yes No

If yes, where? _____

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PHYSICIAN

Patient's Physician _____ City, State _____

Last seen _____ Reason _____

Next appointment _____ Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____

Reason _____

Name _____ City, State _____

Reason _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has the patient had? Please check all that apply

(DK/U=Don't Know or Understand)

Yes	No	DK/U	
			Birth defects or hereditary?
			Bone fractures or major injuries?
			Any injuries to face, head, neck?
			Arthritis or joint problems?
			Cancer, tumor, radiation treatment or chemotherapy?
			Endocrine or thyroid problems?
			Diabetes or low sugar?
			Kidney problems?
			Immune system problems?
			History of osteoporosis?
			Gonorrhea, syphilis, herpes, sexually transmitted diseases?
			Excessive bleeding or bruising, anemia?

Yes	No	DK/U	
			AIDS or HIV positive?
			Hepatitis, jaundice, or other liver problems?
			Polio, mononucleosis, tuberculosis, pneumonia?
			Seizures, fainting spells, neurologic problems?
			Mental health disturbance or depression?
			Frequent headaches or migraines?
			History of eating disorder (anorexia, bulimia)?
			High or low blood pressure?
			Chest pain, shortness of breath, tire easily, swollen ankles?

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Yes	No	DK/U	
			Heart defects, heart murmur, rheumatic heart disease?
			Angina, arteriosclerosis, stroke or heart attack?
			Skin disorder (other than common acne)?
			Does the patient eat a well - balanced diet?
			Vision, hearing, or speech problems?
			Frequent ear infections, colds, throat infections?
			Asthma, sinus problems, hay fever?

Yes	No	DK/U	
			Tonsil or adenoid condition?
			Does the patient frequently breathe through his/her mouth?
			Has the patient ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
			Has the patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate) for bone disorders?

Has the patient had allergies or reactions to any of the following?

Yes	No	DK/U	
			Local anesthetics (novocaine, lidocaine, xylocaine)
			Latex (gloves, balloons)
			Aspirin
			Ibuprofen (Motrin, Advil)
			Metals (jewelry, clothing snaps)
			Penicillin
			Other antibiotics
			Acrylics
			Plant pollens
			Animals
			Foods
			Other substances

DENTAL HISTORY

Now or in the past, has the patient had?

Yes	No	DK/U	
			Erupting teeth very or very late?
			Primary (baby) teeth removed that were not loose?
			Permanent or extra (supernumerary) teeth removed?
			Supernumerary (extra) or congenitally missing teeth?
			Chipped or injured primary or permanent teeth?
			Any sensitive or sore teeth?
			Any lost or broken fillings?
			Jaw fractures, cysts, infections?
			Any teeth treated with root canals or pulpotomies?
			Frequent canker sores or cold sores?

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Yes	No	DK/U	
			History of speech problems or speech therapy?
			Difficulty breathing through nose?
			Mouth breathing habit or snoring at night?
			Frequent oral habits (sucking finger, chewing pen)?
			Teeth causing irritation to lip, cheek or gums?
			Tooth grinding or clenching?
			Clicking, locking in jaw joints?
			Soreness in jaw muscles or face muscles?
			Has the patient been treated for "TMJ" or "TMD" problems?
			Any serious trouble associated with previous dental treatment?
			Has the patient ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

Do you think that any of the patient's activities affect his/her face, teeth, or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Take for _____

Does the patient have (or ever had) a substance abuse problem? _____

Does the patient chew or smoke tobacco? _____

Have you noticed any unusual changes in the patient's face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

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How often does the patient brush? _____ Floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding orthodontic treatment to my dental and/or medical insurance company.

Patient/Parent/Guardian Signature _____

Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in medical or dental health.

Patient/Parent/Guardian Signature _____

Date _____