American Association of Orthodontists®

CONFIDENTIAL

Medical Dental History Form For Patients Under Age 18

PATIENT

Date _____

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

Prefers to be called _____ Hobbies, activities _____

Birth date _____ What sex was the patient assigned on their birth certificate? _____ ☐ Male ☐ Female

What is the patient's current gender identification? ☐ Male ☐ Female ☐ Other

What are the patient's preferred pronouns? _____

Social Security # _____

School _____ Grade _____ E-mail address(es) _____

Home address _____ City, State, Zip code _____

Home phone _____ Cell phone _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (*check all that apply*) ☐ Parent 1/Guardian ☐ Parent 2/Guardian ☐ Parent 3/Guardian ☐ Parent 4/Guardian

☐ Other, if other, what is the relationship? _____

Parent 1/Guardian full name _____

Occupation _____ E-mail address _____

Address (*if different*) _____

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

Work phone _____

Parent 2/Guardian full name _____

Occupation _____ E-mail address _____

Address (*if different*) _____

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

Work phone _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her/their teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Sibling name _____ age _____ had orthodontic treatment? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____

Address (*if different than page 1*) _____ City, State, Zip _____

Cell phone _____ Home phone _____ E-mail address(es) _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name _____ Birth date _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID# _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

MEDICAL INSURANCE

Policy holder's full name _____

Insurance Company _____

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 _____

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, mark yes, no, or don't know/understand (dl/u).

PATIENT HEALTH INFORMATION

Does the patient take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

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

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

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

MEDICAL HISTORY

Now or in the past, has your child had:

Yes	No	DK/U	
☐	☐	☐	Emotional, sensory or developmental issues?
☐	☐	☐	Hereditary or developmental conditions?
☐	☐	☐	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?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, pneumonia?
☐	☐	☐	Seizures, fainting spells, neurologic problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Frequent headaches or migraines

Yes	No	DK/U	
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Does your child eat a well-balanced diet?
☐	☐	☐	Vision, hearing, or speech problems?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	☐	Tonsil or adenoid condition?
☐	☐	☐	Does your child frequently breathe through his/her mouth?
☐	☐	☐	Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?
☐	☐	☐	Has your child ever taken oral medication for bone disorders or cancer such as bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

MEDICAL HISTORY continued

Has your child 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)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Plant pollens
☐	☐	☐	Animals
☐	☐	☐	Foods
☐	☐	☐	Other substances _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes	No	DK/U	
☐	☐	☐	Erupting teeth very early 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?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	History of speech problems?
☐	☐	☐	Frequent oral habits (sucking finger, chewing pen, etc)?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of tongue thrust?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of fingernail biting?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	Frequent habit of lip sucking?
			Current ___ Yes ___ No Age stopped ___
☐	☐	☐	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 your child been treated for “TMJ” or “TMD” problems?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Has your child ever been diagnosed with gum disease or pyorrhea?

How often does your child brush? _____ Floss? _____

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? _____

RELEASE AND WAIVER

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

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 my child’s medical or dental health.

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____
Parent/Guardian Signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes _____
Parent/Guardian Signature _____ Date _____
Dental Staff Signature _____ Date _____

Changes _____
Parent/Guardian Signature _____ Date _____
Dental Staff Signature _____ Date _____

Quality of Life Survey

Evaluation of Sleep-Disordered Breathing

For each question below, please circle the number that best describes how often each symptom or problem has occurred during the past 4 weeks (or since the last survey if sooner).

	none of the time	hardly any of the time	a little of the time	some of the time	a good bit of the time	most of the time	all of the time
Sleep Disturbances							
During the past 4 weeks, how often has your child had...							
...loud snoring	1	2	3	4	5	6	7
...breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
...choking or gasping sounds while asleep?	1	2	3	4	5	6	7
...restless sleep or frequent awakening from sleep?	1	2	3	4	5	6	7
Physical Suffering							
During the past 4 weeks, how often has your child had...							
...mouth breathing because of nasal obstruction?	1	2	3	4	5	6	7
...frequent colds or upper respiratory infections?	1	2	3	4	5	6	7
...nasal discharge or runny nose?	1	2	3	4	5	6	7
...difficulty in swallowing foods?	1	2	3	4	5	6	7
Emotional Distress							
During the past 4 weeks, how often has your child had...							
...mood swings or temper tantrums?	1	2	3	4	5	6	7
...aggressive or hyperactive behavior?	1	2	3	4	5	6	7
...discipline problems?	1	2	3	4	5	6	7
Daytime Problems							
During the past 4 weeks, how often has your child had...							
...excessive drowsiness or sleepiness?	1	2	3	4	5	6	7
...poor attention span or concentration?	1	2	3	4	5	6	7
...difficulty getting out of bed in the morning?	1	2	3	4	5	6	7
Caregiver Concerns							
During the past 4 weeks, how often has your child had...							
...caused you to worry about your child's general health?	1	2	3	4	5	6	7
...created concern that your child is not getting enough air?	1	2	3	4	5	6	7
...interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
...made you frustrated	1	2	3	4	5	6	7

Overall, how would you rate your child's quality of life as a result of the above problems?

0	1	2	3	4	5	6	7	8	9	1

Pediatric Sleep Questionnaire

Patient's Name: _____ Date: _____

While sleeping, does your child...	Yes	No	Don't Know
Snore more than half the time?	☐	☐	☐
Always snore?	☐	☐	☐
Snore loudly?	☐	☐	☐
Have heavy or loud breathing?	☐	☐	☐
Have trouble breathing/struggle to breathe?	☐	☐	☐
Have you ever...	☐	☐	☐
Seen your child stop breathing during sleep?	☐	☐	☐
Does your child...	☐	☐	☐
Tend to breathe through their mouth while awake?	☐	☐	☐
Have a dry mouth upon waking up in the morning?	☐	☐	☐
Occasionally wet the bed?	☐	☐	☐
Wake up feeling un-refreshed in the morning?	☐	☐	☐
Have a problem with sleepiness during the day?	☐	☐	☐
Has a teacher or supervisor commented that your child appears to sleep during the day?	☐	☐	☐
Is it hard to wake your child in the morning?	☐	☐	☐
Does your child wake up with headaches?	☐	☐	☐
Did your child stop growing at a normal rate at any time since birth?	☐	☐	☐
Is your child overweight?	☐	☐	☐
My child often...	☐	☐	☐
Does not seem to listen when spoken to directly.	☐	☐	☐
Has difficulty organizing tasks.	☐	☐	☐
Is easily distracted by extraneous stimuli.	☐	☐	☐
Fidgets with hands/feet or squirms in seat.	☐	☐	☐
Is always "on the go" or often acts as if "driven by a motor."	☐	☐	☐
Frequently interrupts or intrudes on others (e.g. butts into conversations or games).	☐	☐	☐

Total number of 'Yes' responses: _____

If eight or more statements are answered with 'Yes,' consider referring for sleep evaluation.