CONFIDENTIAL Date:____________________

American Association of Orthodontists

MEDICAL DENTAL HISTORY FORM - **FOR PATIENTS UNDER 18 YEARS OF AGE**

Patient's First Name: ________________________ Middle: ____________ Last: ______________________________

Birthdate: ______________Age:_________ Sex: ❒ Male ❒ Female

Parent/Guardian's First Name __________________Middle: ____________Last: ______________________________

Parent is Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒

Father's Height ____________ft. ______________in. Mother's Height______________ft. _____________________in.

No. of brothers & sisters ______ Ages __________Other Family Members Treated ___________________________

Patient's Birth Weight ________lbs. Present Weight___________________ Height __________ft. ______________in.

Musical Instruments Played___________________Favorite Sports, Hobbies & Avocations ______________________

Name of Patient's Dentist ____

MEDICAL HISTORY

For the following questions mark 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.

❒ **yes** ❒ **no** ❒ **dk/u** Does patient follow directions?
❒ **yes** ❒ **no** ❒ **dk/u** Does patient brush his/her teeth conscientiously?
❒ **yes** ❒ **no** ❒ **dk/u** Does patient have learning disabilities or need extra help with instructions?
❒ **yes** ❒ **no** ❒ **dk/u** Is patient sensitive, self-conscious?
❒ **yes** ❒ **no** ❒ **dk/u** Birth defects or hereditary problems?
❒ **yes** ❒ **no** ❒ **dk/u** Bone fractures, any major accidents?
❒ **yes** ❒ **no** ❒ **dk/u** Rheumatoid or arthritic conditions
❒ **yes** ❒ **no** ❒ **dk/u** Endocrine or thyroid problems?
❒ **yes** ❒ **no** ❒ **dk/u** Kidney problems?
❒ **yes** ❒ **no** ❒ **dk/u** Diabetes?
❒ **yes** ❒ **no** ❒ **dk/u** Cancer or been treated for a tumor?
❒ **yes** ❒ **no** ❒ **dk/u** Stomach ulcer or hyperacidity?
❒ **yes** ❒ **no** ❒ **dk/u** Polio, mononucleosis, tuberculosis, pneumonia?
❒ **yes** ❒ **no** ❒ **dk/u** Problems of the immune system?
❒ **yes** ❒ **no** ❒ **dk/u** AIDS or HIV Positive?
❒ **yes** ❒ **no** ❒ **dk/u** Hepatitis, jaundice or liver problem?
❒ **yes** ❒ **no** ❒ **dk/u** Fainting spells, seizures, epilepsy or neurologic disease?
❒ **yes** ❒ **no** ❒ **dk/u** Mental health or behavioral problems
❒ **yes** ❒ **no** ❒ **dk/u** Vision, hearing, tasting or speech difficulties?
❒ **yes** ❒ **no** ❒ **dk/u** Loss of weight recently, poor appetite?
❒ **yes** ❒ **no** ❒ **dk/u** Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
❒ **yes** ❒ **no** ❒ **dk/u** High or low blood pressure?
❒ **yes** ❒ **no** ❒ **dk/u** Easily tired?

❒ **yes** ❒ **no** ❒ **dk/u** Chest pain, shortness of breath or swelling ankles?
❒ **yes** ❒ **no** ❒ **dk/u** Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
❒ **yes** ❒ **no** ❒ **dk/u** Skin disorder?
❒ **yes** ❒ **no** ❒ **dk/u** Do you have a normal and good diet?
❒ **yes** ❒ **no** ❒ **dk/u** Frequent headaches, colds or sore throats?
❒ **yes** ❒ **no** ❒ **dk/u** Eye, ear, nose, throat condition?
❒ **yes** ❒ **no** ❒ **dk/u** Hayfever, asthma, sinus trouble, hives?
❒ **yes** ❒ **no** ❒ **dk/u** Tonsil or adenoid conditions?
❒ **yes** ❒ **no** ❒ **dk/u** Allergies or drug reactions?
Describe: ______________________________
❒ **yes** ❒ **no** ❒ **dk/u** Taking medication, nutrient supplements or non prescription medicine? Please name them:
____
❒ **yes** ❒ **no** ❒ **dk/u** Currently have or ever had a substance abuse problem?
❒ **yes** ❒ **no** ❒ **dk/u** Operations?
Describe: ______________________________
❒ **yes** ❒ **no** ❒ **dk/u** Hospitalized?
Describe: ______________________________
❒ **yes** ❒ **no** ❒ **dk/u** Other physical problems or symptoms?
Describe: ______________________________
❒ **yes** ❒ **no** ❒ **dk/u** Being treated by another health care professional?
Describe: ______________________________
❒ **yes** ❒ **no** ❒ **dk/u** In good health?
Date of most recent physical exam? __________

Over >

DENTAL HISTORY

❒ yes ❒ no ❒ dk/u Started teething very early or late?
❒ yes ❒ no ❒ dk/u Primary (baby) teeth removed that were not loose?
❒ yes ❒ no ❒ dk/u Permanent or “extra” (supernumerary) teeth removed?
❒ yes ❒ no ❒ dk/u Supernumerary (extra) or congenitally missing teeth?
❒ yes ❒ no ❒ dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
❒ yes ❒ no ❒ dk/u Teeth sensitive to hot or cold; teeth throb or ache?
❒ yes ❒ no ❒ dk/u Jaw fractures, cysts, mouth infections?
❒ yes ❒ no ❒ dk/u “Dead Teeth”, root canals treated?
❒ yes ❒ no ❒ dk/u Bleeding gums, bad taste, mouth odor?
❒ yes ❒ no ❒ dk/u Periodontal “Gum Problems”?
❒ yes ❒ no ❒ dk/u Food impaction between teeth?
❒ yes ❒ no ❒ dk/u “Gum Boils”, frequent canker sores, cold sores?
❒ yes ❒ no ❒ dk/u Taking any forms of flouride?
❒ yes ❒ no ❒ dk/u Thumb, finger sucking habit?
Until: ______________________________
❒ yes ❒ no ❒ dk/u Abnormal swallowing habit (tongue thrusting)?
❒ 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 Any pain in jaw or ringing in the ears?

❒ yes ❒ no ❒ dk/u Experience any pain or soreness in the muscles of face, or around the ears?
❒ yes ❒ no ❒ dk/u Difficulty encountered in chewing or jaw opening?
❒ yes ❒ no ❒ dk/u Aware of loose, broken or missing restorations (fillings)?
❒ yes ❒ no ❒ dk/u Any teeth irritating, cheek, lip, tongue, palate?
❒ 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 Had any serious trouble associated with any previous dental treatment?
❒ yes ❒ no ❒ dk/u Onset of puberty (approx. date____)
❒ yes ❒ no ❒ dk/u Had a prior orthodontic examination or treatment?
❒ yes ❒ no ❒ dk/u Recently been under another dentist’s care?
Specialist: ______________________________
Other: ______________________________
❒ yes ❒ no ❒ dk/u Had periodontal (gum) treatment?
❒ yes ❒ no ❒ dk/u Any objections to wearing orthodontic appliances (braces) should they be indicated?

What is your primary concern? _______________Why are you here? ______________________________

Date of most recent dental examination? _________________How often do you brush: __________Floss: _______________

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, or problems that might be encountered during treatment? ______________________________

I have read and understand the above questions. 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.

If there are any changes later to this history record or medical/dental status, I will so inform this practice.

____

Signed by Parent or Guardian: **Date Signed:**

Comments: ______________________________

____

____

Pediatric Sleep Questionnaire:
Sleep-Disordered Breathing Subscale

Child's Name: ______________________________ **Study ID #**__________

Person completing form : ________________________ **Date:** ____/_____/_____

Please answer these questions regarding the behavior of your child during sleep and wakefulness. The questions apply to how your child acts in general during the past month, not necessarily during the past few days since these may not have been typical if your child has not been well. You should circle the correct response or print your answers neatly in the space provided. A "Y" means "yes," "N" means "no," and "DK" means "don't know." When you see the word "usually" it means "more than half the time" or "on more than half the night."

	Y	N	DK	
1. While sleeping, does your child:				
Snore more than half of the time?				A2
Always snore?				A3
Snore loudly?				A4
Have a "heavy" or loud breathing?				A5
Have trouble breathing, or struggle to breathe?				A6
2. Have you ever seen your child stop breathing during the night?				A7
3. Does your child?				
Tend to breathe through the mouth during the day……………….........				A24
Have a dry mouth on waking up in the morning? ……………………..				A25
Occasionally wet the bed? ……………………………………………….				A32
4. Does your child?				
Wake up feeling unrefreshed in the morning? ………………………..				B1
Have a problem with sleepiness during the day? …………………….				B2
5. Has a teacher or other supervisor commented that your child appears sleepy during the day? ……………………………………….				B4
6. Is it hard to wake your child up in the morning?				B6
7. Does your child wake up with headaches in the morning? …………….				B7
8. Did your child stop growing at a normal rate at any time since birth? …………………………………………………………………				B9
9. Is your child overweight? ……………………………………………….……				B22
10. This child *OFTEN*:				
Does not seem to listen when spoken to directly ……………………...				C3
Has difficulty organizing tasks and activities …………………………….				C5
Is easily distracted by extraneous stimuli ………………………..				C8
Fidgets with hands or feet or squirms in seat …………………………….				C10
Is "on the go" or often acts as if "driven by a motor" …………………				C14
Interrupts or intrudes on others (e.g. butts into conversation or games) …………………………………………………………………				C18

Date_____________

Confidential Responsible Party Information

A B C

Name_______________________________________ Marital Status_________
Last First Middle

Residence_______________________________________ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_______________________________ Email______________________
Street City State Zip

How long at this address_____________ Previous Address_______________________________
(if less than 3 yrs) Street City State Zip

Home Phone____________________ Work Phone____________________ Cell Phone_________________

Social Security #__________________ Birthdate__________________ Relationship to Patient______________

Employer________________________ Occupation__________________ No. Years Employed_______________

Spouse's Name__________________________________ Relationship to Patient______________
Last First Middle

Employer________________________ Occupation__________________ No. Years Employed_______________

Social Security #__________________ Birthdate__________________ Work Phone_____________________

Confidential Patient Information

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone____________________ Birthdate__________________ Social Security #_________________

If patient is a minor, give parent's or guardian's name_________________________________

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

Insurance Information

Policy Holder's Name__________________________________ and Soc.Sec. #__________________

Insurance Company____________________________ Group No.___________ Union Local No.____________

Insurance Co. Address_____________________________ Insurance Co. Phone_______________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ If yes: ________________________________

Policy Holder's Name__________________________________ and Soc. Sec. #__________________

Insurance Company____________________________ Group No.___________ Union Local No.____________

Insurance Co. Address_____________________________ Insurance Co. Phone_______________

Policy Holder's Employer____

Emergency Information

Name of nearest relative not living with you_______________________________________

Complete Address____

Phone___________________________ Relationship:_______________________________

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor)____

Updates (date & initial)____

CONFIDENTIAL (for record and pretreatment evaluation)
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