

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 (zoledronic 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)?