# Getting To Know You

A B C

A Dento-Medical History Questionnaire

CHILD

DATE ____________

**A**

NAME OF PATIENT ____________ FIRST ____________ MIDDLE ____________ LAST

MALE ________ FEMALE ________ SCHOOL ____________ GRADE ________

AGE ______ BIRTHDATE ______ MONTH ______ DAY ______ YEAR ADOPTED ________ HOME PHONE ____________

NAME OF PARENT(S) OR GUARDIAN(S) ____________ FATHER'S SOC. SEC. # ____________

HOME ADDRESS ____________ NUMBER & STREET ____________ CITY ____________ ZIP

FATHER EMPLOYED BY ____________ BUSINESS PHONE ____________ NO. OF YEARS ______

FATHER'S BUSINESS ADDRESS ____________ CELL PHONE ____________

MOTHER'S FIRST NAME ____________ EMPLOYED BY ____________ NO. OF YEARS ______

MOTHER'S BUS. ADDRESS ____________ SOC. SEC. # ____________ BUSINESS PHONE ____________

MOTHER'S CELL PHONE ____________ RELATIVES TREATED HERE ____________

PATIENT'S DENTIST ____________ CITY ____________

PATIENT'S PHYSICIAN ____________ CITY ____________

**WHAT IS THE PATIENT'S (OR PARENT'S) PRIMARY ORTHODONTIC CONCERN?** ____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________

Successful treatment depends greatly upon the Patient's (and Parent's) complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene.

Are there any restrictions, handicaps or problems we might encounter? ____________

**NOW COMPLETE B through C.**

**B**

## MEDICAL HISTORY

### DOES THE PATIENT FREQUENTLY HAVE ANY OF THE FOLLOWING CONDITIONS?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Indigestion, nausea, vomiting, jaundice | ☐ | ☐ | Blood in stools or in Urine, Kidney or Bladder Condition | ☐ | ☐ |
| Diarrhea, constipation, abdominal cramps | ☐ | ☐ | Headaches, colds, or sore throats each year | ☐ | ☐ |
| Hayfever, Asthma, Eczema, Hives | ☐ | ☐ | Allergies, Sinus problems | ☐ | ☐ |

### HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING CONDITIONS?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Unhealthy infancy, breast- or formula-feeding difficulty | ☐ | ☐ | Polio, Mono, Tuberculosis, Pneumonia, Hepatitis | ☐ | ☐ |
| Bone fractures - any major accidents | ☐ | ☐ | Rheumatic Fever, Heart Condition, Blood disorder | ☐ | ☐ |
| Change in weight recently - poor appetite | ☐ | ☐ | High or Low Blood Pressure - Tires easily? | ☐ | ☐ |
| Excessive bleeding - black and blue tendency | ☐ | ☐ | Insomnia or "Hyperactive" condition, Muscle or Back Pain | ☐ | ☐ |
| Growths, tumors, unusual swellings | ☐ | ☐ | A nervous breakdown - Psychological, Emotional Condition | ☐ | ☐ |
| Diabetes - Bowel or Urinary Condition | ☐ | ☐ | A tendency to cry or get upset easily - Arthritis | ☐ | ☐ |
| | | | Vision, Hearing, Tasting, or Speech Difficulties | ☐ | ☐ |
| | | | Eye, Ear, Nose, Throat condition, Skin Disorder | ☐ | ☐ |

Is Patient under a physician's care? ______ Why? ____________

HIV Status: ☐ unknown ☐ positive ☐ negative

Please list any serious or recurrent illness (physical or mental) ____________

If the patient is a girl between 9 - 15 years, has she begun menstrual cycles? ______

Other physical problems or symptoms ____________

Operated on for ____________

Been hospitalized for ____________

Allergies or Reaction to Drugs, Medicines ____________

Is patient on medication? ______ Please name it ____________

**C**

## DENTAL HISTORY

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Start teething very early or late | ☐ | ☐ | Nail-biting habit to age ______ Mouth breathing habit | ☐ | ☐ |
| Baby teeth removed that were not loose | ☐ | ☐ | Tooth-grinding, jaw-clenching, clicking, locking, pain | ☐ | ☐ |
| Chipped or otherwise injured baby or permanent teeth | ☐ | ☐ | Difficulty encountered in breathing, chewing | ☐ | ☐ |
| Teeth sensitive to hot or cold. Teeth throb or ache | ☐ | ☐ | Presently have extra or congenitally missing teeth | ☐ | ☐ |
| Jaw fractures, cysts, abscess, other infections | ☐ | ☐ | Permanent or "Extra" (super-numerary) teeth removed | ☐ | ☐ |
| "Dead teeth" - root canals treated | ☐ | ☐ | Aware of loose, broken, or missing restorations (fillings) | ☐ | ☐ |
| Bleeding gums, bad taste, mouth odor | ☐ | ☐ | Any teeth irritating cheek, lip, tongue, palate | ☐ | ☐ |
| Gigivitis, "Vincents" infection, "Pockets" | ☐ | ☐ | Concerned about spaced, crooked or protruding teeth | ☐ | ☐ |
| Food impaction between teeth, Periodontal Problem | ☐ | ☐ | Aware of or concerned about under- or over-developed jaw | ☐ | ☐ |
| "Gum Boils" - frequent canker sores, "cold sores" | ☐ | ☐ | Any relative with similar tooth or jaw relationship | ☐ | ☐ |
| Lip-, Cheek-, Tongue-biting, soreness, or bleeding | ☐ | ☐ | Any wisdom tooth problem | ☐ | ☐ |
| Thumb-, Finger-, Tongue-sucking habit until age ______ | ☐ | ☐ | Abnormal Swallowing Habit (Tongue Thrust) to age ______ | ☐ | ☐ |

Has Patient had any other dental condition or symptom (Explain) ____________

Has Patient recently been under another dentist's care (specialist - other?) ______

Would Patient object to wearing orthodontic appliances (braces) should they be indicated? ______

I understand that where appropriate credit bureau reports may be obtained.

Does he/she follow instructions readily? ____________

Has Patient ever had Orthodontic Treatment or worn a "retainer" or bite plate? ______

Has Patient ever had Periodontal Treatment or "Gingivectomy"? ______

SIGNED ____________