Anchorage Orthodontic Associates
1000 O'Malley Road, Suite 105
Anchorage, AK 99515

Patient's Health Information

Name:______________________________Date:____________
DOB:____________Age:_____________Gender: M F

Your answers are for our records only, and are confidential. A thorough medical history is essential for a complete orthodontic evaluation. *Parent/guardian, please answer questions for patient.*

Patient's General Information

What concerns you about your teeth?
How do you feel about orthodontic treatment?
Whom may we thank for introducing you to our office?
Why did you select our office?
Have you ever had previous orthodontic treatment or consultations?
☐ Y ☐ N Describe
Do you play a musical instrument? Explain.
Child's school Grade
Brother/sister name(s) Age(s)
Had orthodontic treatment ☐ Y ☐ N If yes, where?
Have any other family members been treated in this office?
Do you think that any of your work or leisure activities affect your teeth or jaws? ☐ Y ☐ N Explain

Patient's Dentist:__________________________

Phone Last seen Reason
Next appointment
Other dentists/specialists being seen

Patient's Physician:________________________

Phone Last seen Reason
Most recent physical exam

Patient's Medical History

Answer yes, no, or don't know/understand (dk/u).

☐ Y ☐ N ☐ DK/U Birth defects or hereditary problems?
☐ Y ☐ N ☐ DK/U Bone fractures or major injuries?
☐ Y ☐ N ☐ DK/U Any injuries to head, face, neck?
☐ Y ☐ N ☐ DK/U Arthritis or joint problems?
☐ Y ☐ N ☐ DK/U Endocrine or thyroid problems?
☐ Y ☐ N ☐ DK/U Diabetes or low sugar?
☐ Y ☐ N ☐ DK/U Kidney problems?
☐ Y ☐ N ☐ DK/U Cancer, tumor, radiation treatment or chemotherapy?
☐ Y ☐ N ☐ DK/U Stomach ulcer, hyperacidity, acid reflux?
☐ Y ☐ N ☐ DK/U Immune system problems?
☐ Y ☐ N ☐ DK/U History of osteoporosis?
☐ Y ☐ N ☐ DK/U Gonorrhea, syphilis, herpes, sexually transmitted diseases?
☐ Y ☐ N ☐ DK/U AIDS or HIV positive?
☐ Y ☐ N ☐ DK/U Hepatitis, jaundice, or other liver problem?
☐ Y ☐ N ☐ DK/U Polio, mononucleosis, tuberculosis, pneumonia?
☐ Y ☐ N ☐ DK/U Seizures, fainting spells, neurologic problem?
☐ Y ☐ N ☐ DK/U Mental health disturbance or depression?
☐ Y ☐ N ☐ DK/U Vision, hearing, or speech problems?
☐ Y ☐ N ☐ DK/U History of eating disorder (anorexia, bulimia)?
☐ Y ☐ N ☐ DK/U High or low blood pressure?
☐ Y ☐ N ☐ DK/U Excessive bleeding or bruising, anemia?
☐ Y ☐ N ☐ DK/U Heart defects, heart murmur, rheumatic heart disease?
☐ Y ☐ N ☐ DK/U Chest pain, shortness of breath, tire easily, swollen ankles?
☐ Y ☐ N ☐ DK/U Angina, arteriosclerosis, stroke, or heart attack?
☐ Y ☐ N ☐ DK/U Skin disorder (other than common acne)?
☐ Y ☐ N ☐ DK/U Frequent headaches or migraines?
☐ Y ☐ N ☐ DK/U Frequent ear infections, colds, throat infections?
☐ Y ☐ N ☐ DK/U Asthma, sinus problems, hay fever?
☐ Y ☐ N ☐ DK/U Tonsil or adenoid condition?
☐ Y ☐ N ☐ DK/U Do you frequently breathe through your mouth?
☐ Y ☐ N ☐ DK/U Have you or your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), or Didronel (etidronate) for bone disorders or cancer?
☐ Y ☐ N ☐ DK/U Have you or your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate), or Didronel (etidronate) for bone disorders?
☐ Y ☐ N Women: Are you pregnant?
☐ Y ☐ N Are you trying to become pregnant?

Have you had allergies or reactions to any of the following?

☐ Y ☐ N ☐ DK/U Local anesthetics (novocaine, lidocaine, xylocaine)?
☐ Y ☐ N ☐ DK/U Latex (gloves, balloons)?
☐ Y ☐ N ☐ DK/U Ibuprofen (Motrin, Advil)?
☐ Y ☐ N ☐ DK/U Penicillin?
☐ Y ☐ N ☐ DK/U Other antibiotics?
☐ Y ☐ N ☐ DK/U Metals (jewelry, clothing snaps)?
☐ Y ☐ N ☐ DK/U Acrylics?
☐ Y ☐ N ☐ DK/U Plant pollens?
☐ Y ☐ N ☐ DK/U Other substances?

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

Medication___________________ Taken For__________________
Medication___________________ Taken For__________________
Medication___________________ Taken For__________________
Medication___________________ Taken For__________________

☐ Y ☐ N Do you or have you ever had a substance abuse problem?
☐ Y ☐ N Do you chew or smoke tobacco?

Family Medical History

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

☐ Y ☐ N ☐ DK/U Bleeding disorders
☐ Y ☐ N ☐ DK/U Diabetes
☐ Y ☐ N ☐ DK/U Arthritis
☐ Y ☐ N ☐ DK/U Severe allergies
☐ Y ☐ N ☐ DK/U Unusual dental problems
☐ Y ☐ N ☐ DK/U Jaw size imbalance
Other family medical conditions?

Patient's Dental History

☐ Y ☐ N ☐ DK/U Erupting teeth very early or very late?
☐ Y ☐ N ☐ DK/U Primary (baby) teeth removed that were not loose?
☐ Y ☐ N ☐ DK/U Permanent or extra (supernumerary) teeth removed?
☐ Y ☐ N ☐ DK/U Chipped or injured primary or permanent teeth?
☐ Y ☐ N ☐ DK/U Any sensitive or sore teeth?
☐ Y ☐ N ☐ DK/U Bleeding gums, bad taste, or mouth odor?
☐ Y ☐ N ☐ DK/U Jaw fractures, cysts, infections?
☐ Y ☐ N ☐ DK/U Any teeth treated with root canals or pulpotomies?
☐ Y ☐ N ☐ DK/U "Gum boils," frequent canker sores, or cold sores?
☐ Y ☐ N ☐ DK/U History of speech problems or speech therapy?
☐ Y ☐ N ☐ DK/U Difficulty breathing through nose?
☐ Y ☐ N ☐ DK/U Food impaction between the teeth?
☐ Y ☐ N ☐ DK/U Mouth breathing habit or snoring at night?
☐ Y ☐ N ☐ DK/U Frequent oral habits (sucking finger, chewing pen, etc.)?
☐ Y ☐ N ☐ DK/U Teeth causing irritation to lip, cheek, or gums?
☐ Y ☐ N ☐ DK/U Abnormal swallowing (tongue thrust)?
☐ Y ☐ N ☐ DK/U Clicking, locking in jaw joints?
☐ Y ☐ N ☐ DK/U Soreness in jaw muscles or face muscles?
☐ Y ☐ N ☐ DK/U Ringing in ears, difficulty chewing or opening jaw?
☐ Y ☐ N ☐ DK/U Have you ever been treated for "TMJ" or "TMD" problems?
☐ Y ☐ N ☐ DK/U Any broken or missing fillings?
☐ Y ☐ N ☐ DK/U Any serious trouble with previous dental treatment?
☐ Y ☐ N ☐ DK/U Have you ever been diagnosed with gum disease or pyorrhea?
☐ Y ☐ N ☐ DK/U Have you noticed any changes in your face or jaws?
How often do you brush your teeth?_______________
How often do you floss your teeth?________________

Release and Waiver

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

Signature______________________________ Date______________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his 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 or my child's medical or dental health.

Signature______________________________ Date______________

Updates or Changes

Changes
Patient Signature_____________________Date______________
Dental Staff Signature_________________Date______________

Changes
Patient Signature_____________________Date______________
Dental Staff Signature_________________Date______________