Alexander Orthodontics -NY-

# ORTHODONTIC, MEDICAL AND DENTAL HISTORY

Your answers to the following questions will be helpful in planning an orthodontic treatment.

**Patient's Name:** _____ **Date:** _____

1. Date of your last dental cleaning & checkup: _____ Dentist name: _____

2. Do you have an allergy to LATEX? Yes _____ No _____

3. Please list any other allergies: _____

4. Are you a smoker (circle one): Current Former Never

5. If you are a current **or** former smoker: # Packs/Day: _____ # of Years of Smoking: _____

6. Are you presently under a physician's care? Yes _____ No _____

   For what? _____

7. Are you taking any medication? Yes _____ No _____

   What kind? _____

8. Are you currently taking medication to build bone-density like Actonel or Boniva? Yes _____ No _____

   Name of medication? _____

9. Pharmacy Name & Address: _____

10. Have you ever been diagnosed with rheumatic fever? Yes _____ No _____

    Heart disease? Yes _____ No _____

    Diabetes? Yes _____ No _____

    Convulsions? Yes _____ No _____

11. Have you experienced any other problems? Yes _____ No _____

    Please describe: _____

12. Have you been ill for more than 5 days in the last year? Yes _____ No _____

    Name of illness: _____

13. Have you ever had extensive x-ray therapy? Yes _____ No _____

14. Have you ever had operations or injuries of the head or neck? Yes _____ No _____

    Please describe: _____

15. Have you ever had a severe blow on the teeth or jaws? Yes _____ No _____

    Please describe: _____

16. Do you consistently have sore or bleeding gums? Yes _____ No _____

17. Have you had any teeth removed? Yes _____ No _____

18. Do you brush your teeth in the morning? Yes _____ No _____

After lunch? Yes _____ No _____

After dinner? Yes _____ No _____

Before bedtime? Yes _____ No _____

19. Do/Did (CIRCLE) you ever suck your fingers, thumb, lips or tongue? Yes _____ No _____

20. Do/Did (CIRCLE) you bite your lips, tongue, fingernails, pencils or other objects? Yes _____ No _____

21. Do you grit, grind, or clench your teeth at night? Yes _____ No _____

22. Have your tonsils and/or adenoids been removed? Yes _____ No _____

23. Do you breathe predominantly through your mouth? Yes _____ No _____

24. Do you play a musical instrument? Yes _____ No _____

What Kind? _____

25. Is there any difficulty chewing or swallowing food? Yes _____ No _____

26. Is there any clicking or popping of your jaw joints when opening or closing? Yes _____ No _____

27. Reasons for seeking orthodontic treatment: (CHECK ALL THAT APPLY)

Appearance _____ Better Digestion _____ Better Speech _____ Advice of Dentist _____ Advice of Friends _____

28. Do any members of your family or relatives have similar issues of the teeth or jaw? Yes _____ No _____

29. Has any member of your family had orthodontic treatment? Yes _____ No _____

30. Who first noticed the need for orthodontic treatment? (CHECK ALL THAT APPLY)

Self _____ Dentist _____ Other _____

31. Are you concerned about the appearance of your teeth? Yes _____ No _____

32. Have you ever been teased about the appearance of your teeth? Yes _____ No _____

33. Please check which word best describes your attitude towards wearing orthodontic appliances:

Eager _____ Willing _____ Nervous _____ Unwilling _____ Resignation _____

34. Have you previously visited an orthodontist? Yes _____ No _____

If so, when? _____ How was your experience? Good _____ OK _____ Bad _____

35. In most cases orthodontic treatment is relatively pain free and the time goes by quickly. Please list any additional concerns or comments that you believe may be helpful in diagnosing your case and to make your time in treatment as easy and comfortable as possible:

_____

_____

_____

******* Please note that some longer procedures are only done in the mornings *******

333 Aviation Rd. Bldg. A Queensbury, NY 12804 – (518) 793-8511 – AlexanderOrthoNY.com