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 last dental cleaning & check up: _____ Dentist name:_____

2. Does the patient have an allergy to LATEX? Yes _____No_____

3. Please list any other allergies: _____

4. Does the patient need any medications prior to dental work? Yes _____No_____

If so, please list: _____

5. Pharmacy Name & Address: _____

6. Is the patient presently under a physician's care? Yes _____No _____

For what? _____

7. Is the patient taking any medication? Yes _____No _____

What kind? _____

8. Has the patient ever had rheumatic fever? Yes _____No _____

heart disease? Yes _____No _____

diabetes? Yes _____No _____

convulsions? Yes _____No _____

9. Has the patient experienced any other problems? Yes _____No _____

Please describe: _____

10. Has the patient been ill for more than 5 days in the last year? Yes _____No _____

Name of illness: _____

11. Has the patient ever had extensive x-ray therapy? Yes _____No _____

12. Has the patient experienced a sudden increase in height? Yes _____No _____

13. If the patient is a male, has his voice changed or has he started to shave? Yes _____No _____

14. If the patient is a female, has she started her menstrual cycle? Yes _____No _____

15. Has the patient ever had operations or injuries of the head or neck? Yes _____No _____

Please describe: _____

16. Has the patient ever had a severe blow on the teeth or jaws? Yes _____No _____

Please describe: _____

17. Do you consistently have sore or bleeding gums? Yes _____No _____

18. Have any of the patient's teeth been removed? Yes _____No _____

ORTHODONTIC, MEDICAL AND DENTAL HISTORY, *page 2*

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

after lunch? Yes _____ No _____

after dinner? Yes _____ No _____

before bedtime? Yes _____ No _____

20. Does/Did (CIRCLE) the patient ever suck on fingers, thumb, lips or tongue? Yes _____ No _____

21. Does/Did (CIRCLE) the patient bite lips, tongue, fingernails, pencils, other objects? Yes _____ No _____

22. Does the patient grit, grind, or clench his/her teeth at night? Yes _____ No _____

23. Has the patient's tonsils and/or adenoids been removed? Yes _____ No _____

24. Does the patient breathe predominantly through his/her mouth? Yes _____ No _____

25. Does the patient play a musical instrument? Yes _____ No _____

What kind? _____

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

27. Is there any clicking/popping of the patient's jaw joints when opening or closing? Yes _____ No _____

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

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

29. Do any members of the family or relatives have similar issues of the teeth or jaws? Yes _____ No _____

30. Has any member of the patient's family had orthodontic treatment? Yes _____ No _____

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

Parents _____ Patient _____ Dentist _____ Other _____

32. Is the patient concerned about the appearance of his/her teeth? Yes _____ No _____

33. Has the patient ever been teased about the appearance of his/her teeth? Yes _____ No _____

34. Please check which word best describes the patient's attitude towards wearing orthodontic appliances:

Eager _____ Willing _____ Nervous _____ Unwilling _____ Resignation _____

35. Has the patient previously visited an orthodontist? Yes _____ No _____

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

36. 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 the patient's case and to make the patient's time in treatment as easy and comfortable as possible:

_____

_____

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

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