smile ORTHODONTICS

HEALTH AND WELLNESS FORM

PATIENT NAME _____ **DATE** _____

1. ABOUT YOU

Why have you come to the orthodontist today? _____

_____

What concerns you about your smile? _____

_____

2. DENTAL HISTORY

Do you have, or have you had, any of the following?

- ☐ Permanent or "extra" teeth removed
- ☐ Teeth sensitivity or soreness
- ☐ Food impaction between teeth
- ☐ Speech problems
- ☐ Teeth grinding or jaw clenching
- ☐ Pain or soreness in the muscles of the face or around the ears
- ☐ Treated for "TMD" or "TMJ" problems
- ☐ Spaced, crooked, or protruding teeth
- ☐ Wisdom teeth problems
- ☐ Extra or congenitally missing teeth
- ☐ Jaw fractures, cysts, or mouth infections
- ☐ Abnormal swallowing habit (tongue thrusting)
- ☐ Mouth breathing habit, snoring, or difficulty in breathing
- ☐ Pain, clicking, or locking in jaw or ringing in the ears
- ☐ Difficulty in chewing or jaw opening
- ☐ Teeth irritating cheek, lip, tongue, palate, or gums
- ☐ A relative with similar teeth or jaw relationships
- ☐ Frequent oral habits (sucking fingers, chewing pens, etc.)

Have you had previous orthodontic treatment? ☐ Yes ☐ No

Family Dentist's Name _____ Phone # _____

Date Last Seen _____ Reason _____

3. MEDICAL HISTORY/ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Tree Nuts ☐ Other _____

Physician's Name _____

Phone # (_____) _____ Last Visit Date _____

FOR WOMEN

☐ Pregnant / Trying to get pregnant ☐ Nursing

3. MEDICAL HISTORY/ALLERGIES

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bone Disorder
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spinal Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ Other, unlisted

Please explain_____

_____

_____

Are you under a physician's care now? ☐ Yes, please explain_____

Has a doctor ever told you that you require antibiotics before dental treatment? ☐ Yes, please explain_____

Have you ever been hospitalized or had a major operation? ☐ Yes, please explain_____

Have you ever had a serious head or neck injury? ☐ Yes, please explain_____

Do you use tobacco? ☐ Yes, please explain_____

Do you use controlled substances? ☐ Yes, please explain_____

Are you taking any medications, pills, or drugs? ☐ Yes, please explain_____

_____

Have you ever taken intravenous bisphosphonates such as Zometa, Aredia or Didronal for bone disorders or cancer? ☐ Yes, please explain_____

Have you ever taken oral bisphosphonates such as Fosamax, Actonel, Bonioa, Skelid, or Didronel for bone disorders? ☐ Yes, please explain_____

Patient Signature _____ Date_____

Guardian Signature (if under 18) _____ Date_____