

## ORTHODONIC PATIENT HISTORY

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NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Please describe your orthodontic problem (in your own words):

Have you had any previous orthodontic treatment or consultation? Y N

Do you have any allergies? Y N

Are you taking any medications? Y N

If yes, please list \_\_\_\_\_

Have you ever taken any bisphosphonates (i.e. fosamax, alendronate, risedronate, actonel, ibandronate, bonivia, zoledronate, ect.) Y N

Do you now have or have you experienced pain in your jaw joints? Y N

Do you grind your teeth? Y N

Do you have any speech problems? Y N

Do you have, or have you had any thumb or finger sucking habits? Y N

Have you ever experienced an adverse reaction during a medical or dental procedure? Y N

Have you ever experienced serious trauma to your teeth, face, jaw, or head? Y N

Are you under care of a physician for any specific condition? Y N

If yes, please explain:

Check if you have or have ever had:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Artificial Joints or Heart Valves
<input type="checkbox"/> AID/HIV Positive	<input type="checkbox"/> Convulsions or Epilepsy	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Endocrine or Growth Problems
<input type="checkbox"/> Excessive Headaches	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Blood Pressure Problems

I have reviewed the above form and verify that it is correct to the best of my knowledge. If there is a change to my health status, I will promptly inform Dr. Coombs.

\*Patient signature (Parent signature in the case of a minor) \_\_\_\_\_

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### FOR DOCTORS USE

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Classification \_\_\_\_\_ Midlines \_\_\_\_\_

Overjet \_\_\_\_\_ Overbite \_\_\_\_\_ Crowding \_\_\_\_\_ Spacing \_\_\_\_\_

Primary Teeth \_\_\_\_\_ Profile \_\_\_\_\_ Smile Line \_\_\_\_\_

Habits \_\_\_\_\_

Other:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Advice \_\_\_\_\_

Retention \_\_\_\_\_ Treatment Time \_\_\_\_\_