Health History

Patient Name: _____

Your estimate of patient's health: ☐ Good ☐ Fair ☐ Poor
Have there been any changes in health in the last year? ☐ Yes ☐ No Explain: _____
Does the patient have any history of major illness? ☐ Yes ☐ No Explain: _____
Have tonsils/adenoids been removed? ☐ Yes ☐ No Date _____
Females: Have you started menstruation? ☐ Yes ☐ No First Date _____
Are you pregnant? ☐ Yes ☐ No Months Pregnant: ___ Due Date _____

Check any of the following for which patient has a history of:

	Y	N		Y	N		Y	N
Diabetes	☐	☐	Heart Murmur	☐	☐	Mental Disability/Illness	☐	☐
Autoimmune Disease	☐	☐	Heart Trouble	☐	☐	Behavioral Problems/Concerns	☐	☐
HIV / AIDS	☐	☐	High Blood Pressure	☐	☐	Mental or Behavioral Therapy	☐	☐
Endocrine	☐	☐	Fainting or Dizziness	☐	☐	Autism Spectrum	☐	☐
Prolonged Bleeding	☐	☐	Frequent Headaches	☐	☐	Sleep apnea	☐	☐
Epilepsy	☐	☐	Allergies/Hay Fever	☐	☐	Snoring	☐	☐
Bone Disorder	☐	☐	Hives or skin rash	☐	☐	Mouth Breathing	☐	☐
Arthritis	☐	☐	Asthma	☐	☐	Sinus Troubles	☐	☐
Cold Sores or Canker Sores	☐	☐	Smoking	☐	☐	Daytime tiredness or sleepiness	☐	☐

Any condition not mentioned above:

Please List Any Medications You Are Taking: _____

Have you taken Bisphosphonates (Boniva/Fosamax/Reclast)? ☐ Yes ☐ No Last taken: _____

Are you allergic to or have adverse reactions to:

	Y	N		Y	N		Y	N
Penicillin	☐	☐	Latex	☐	☐	Local anesthetics	☐	☐
Erythromycin	☐	☐	Motrin (Ibuprofin)	☐	☐	Nickel or other metal	☐	☐
Tetracycline	☐	☐	Aspirin	☐	☐	Other Allergies	☐	☐

Dental History

	Y	N	
Any history of injuries to face, mouth, or teeth?	☐	☐	
Has patient ever sucked thumb, finger, or lip, pen/pencil, etc?	☐	☐	Until what age? ___
Does patient have any speech problems?	☐	☐	
Do you need to take antibotics prior to dental proceeds (e.g., for prosthetic heart valves)	☐	☐	
Has patient been informed of any missing or extra permanent teeth?	☐	☐	
Does patient have any difficulty chewing food?	☐	☐	
Does patient have bleeding gums?	☐	☐	
Has patient ever had jaw pain/trauma/clicking/popping or other TMJ problems?	☐	☐	
Is patient dissatisfied with or sensitive about their dental appearance?	☐	☐	
Has patient had previous orthodontic treatment or a consult?	☐	☐	

Has either parent had orthodontic treatment? ___ Were extractions necessary?____Was jaw surgery necessary?___

What are your primary concerns that brought you in for an orthodontic evaluation? _____
Date of last general dental visit _____ What was done? _____
Rate your smile on a scale of 1 to 10, 10 being great: _____

I certify the above to be true to the best of my knowledge. I authorize the doctor to examine me (or my child) and obtain the necessary diagnostic information. I authorize Carlsbad Village Orthodontics to communicate through email any necessary information regarding my treatment to my treating dentists.

_____ _____ _____ _____
Patient or Parent Signature Date Doctor Signature Date

UPDATES TO HEALTH HISTORY: Y N

Date ___/_____/___ Any changes to the medical history? ☐ ☐ Explain: _____ Inital: _____ Dr: _____
Date ___/_____/___ Any changes to the medical history? ☐ ☐ Explain: _____ Inital: _____ Dr: _____