



**CONFIDENTIAL**

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www.schoolhouseorthodontics.com

## Health History Form for Patients Under 18 Years of Age

### Patient Information

**Patient's Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_  
**Birth Date:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Prefers to be Called:** \_\_\_\_\_  
**Social Security Number/ S.I.N.:** \_\_\_\_\_ **Home Phone Number:** \_\_\_\_\_  
**Patient's Address:** \_\_\_\_\_  
**Attends School At:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Musical Instruments Played:** \_\_\_\_\_  
**Sports and/or Hobbies:** \_\_\_\_\_  
**No. of Brothers and Sisters:** \_\_\_\_\_ **Ages:** \_\_\_\_\_  
**Other family members treated here:** \_\_\_\_\_  
**Custodial Parent(s) or Guardian(s):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Email address:** \_\_\_\_\_  
**Home:** \_\_\_\_\_ **Cell phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_  
**How do you prefer to be contacted?** \_\_\_\_\_

### Medical Contact Information

**Name of Patient's Dentist:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
**Dentist's Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip/Postal Code:** \_\_\_\_\_  
**Date Last Seen:** \_\_\_\_\_ **Reason:** \_\_\_\_\_  
**Name of Patient's Physician(s):** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_  
**Physician's Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip/Postal Code:** \_\_\_\_\_  
**Date Last Seen:** \_\_\_\_\_ **Reason:** \_\_\_\_\_

### Insurance/Financial Information

**Insured #1 Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Years at this address:** \_\_\_\_\_  
**If less than five years, previous address:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Dental Insurance Company:** \_\_\_\_\_  
**Insurance Company Phone Number:** \_\_\_\_\_  
**ID#:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_  
**Insured #2 Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Years at this address:** \_\_\_\_\_  
**If less than five years, previous address:** \_\_\_\_\_  
**Phone #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_  
**Employer:** \_\_\_\_\_  
**Dental Insurance Company:** \_\_\_\_\_  
**Insurance Company Phone Number:** \_\_\_\_\_  
**ID#:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**What are your main concerns today?**

**How did you select our office?**

**For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.**

## Medical History

**Now or in the past, has the patient had:**

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tires easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?
- yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes no dk/u Skin disorder?
- yes no dk/u Does the patient eat an unbalanced diet?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Eye, ear, nose or throat condition?
- yes no dk/u Hayfever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adenoid conditions?

**Allergies or reactions to any of the following:**

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
- yes no dk/u Aspirin
- yes no dk/u Ibuprofen (Motrin, Advil)
- yes no dk/u Penicillin or other antibiotics
- yes no dk/u Sulfa drugs
- yes no dk/u Codeine or other narcotics
- yes no dk/u Metal (jewelry, clothing snaps)
- yes no dk/u Latex (gloves, balloons)
- yes no dk/u Vinyl
- yes no dk/u Acrylic
- yes no dk/u Animals
- yes no dk/u Foods (specify) \_\_\_\_\_
- yes no dk/u Other substances (specify) \_\_\_\_\_
- yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.
- Medication \_\_\_\_\_ Taken for: \_\_\_\_\_
- Medication \_\_\_\_\_ Taken for: \_\_\_\_\_
- Medication \_\_\_\_\_ Taken for: \_\_\_\_\_
- yes no dk/u Does the patient currently have or ever had a substance abuse problem?
- yes no dk/u Does the patient chew or smoke tobacco?
- yes no dk/u Operations? Specify: \_\_\_\_\_
- yes no dk/u Hospitalized? Specify: \_\_\_\_\_
- yes no dk/u Other physical problems or symptoms: Specify: \_\_\_\_\_
- yes no dk/u Being treated by another health care professional? Specify: \_\_\_\_\_
- Date of most recent exam: \_\_\_\_\_

Are there any other medical conditions that we should be aware of?  
Specify: \_\_\_\_\_

### Patient Profile

- yes no dk/u Does patient follow directions well?
- yes no dk/u Does patient brush his/her teeth conscientiously?
- yes no dk/u Does patient have learning disabilities or need extra help with instructions?
- yes no dk/u Is patient sensitive or self-conscious about teeth?

### Girls Only

- yes no dk/u Has the patient started her monthly periods?  
If so, approximately when? \_\_\_\_\_
- yes no dk/u Is the patient pregnant?

### Boys Only

- yes no dk/u Has the patient started puberty (voice changes)?

### Family Medical History

**Do the patient's parents or siblings have any of the following health problems? If so, please explain.**

- Bleeding disorders \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Metabolic disturbances \_\_\_\_\_
- Severe allergies \_\_\_\_\_
- Unusual dental problems \_\_\_\_\_
- Jaw size imbalance \_\_\_\_\_
- Any other family medical conditions that we should know about?  
\_\_\_\_\_

## Dental History

- |  |  |
|--|--|
| <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Started teething very early or late?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Primary (baby) teeth removed that were not loose?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Permanent or "extra" (supernumerary) teeth removed?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Supernumerary (extra) or congenitally missing teeth?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Chipped or otherwise injured primary (baby) or permanent teeth?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Teeth sensitive to hot or cold; teeth throb or ache?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Jaw fractures, cysts or mouth infections?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u "Dead teeth" or root canals treated?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Bleeding gums, bad taste or mouth odor?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Periodontal "gum problems"?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Food impaction between teeth?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Thumb, finger, or sucking habit? Until what age? _____</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Abnormal swallowing habit (tongue thrusting)?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u History of speech problems?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Mouth breathing habit, snoring or difficulty in breathing?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Tooth grinding, jaw clenching, clicking or locking?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Any pain in jaw or ringing in the ears?</p> | <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Any pain or soreness in the muscles of the face or around the ears?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Difficulty encountered in chewing or jaw opening?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Aware of loose, broken or missing restorations (fillings)?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Any teeth irritating cheek, lip, tongue or palate?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Concerned about spaced, crooked or protruding teeth?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Aware or concerned about under or over developed jaw?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u "Gum Boils", frequent canker sores or cold sores?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Taking any forms of fluoride?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Any relative with similar tooth or jaw relationships?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Had periodontal (gum) treatment?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Any serious trouble associated with any previous dental treatment?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Ever had a prior orthodontic examination or treatment ?</p> <p><input type="checkbox"/>yes <input type="checkbox"/>no <input type="checkbox"/>dk/u Been under another dentist's care?<br/> Specialist _____<br/> Other _____</p> |
|--|--|

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

What is your primary concern today? \_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_

I consent to allow Schoolhouse Orthodontics, LTD to use the patients records and photos for educational or publication purposes as they deem necessary.

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_

I understand that credit bureau information may be obtained.