THE Smiling ORTHODONTIST

Original Date:

Date Revised:

Dr Berna Kim
BDSc (Hons)(Qld), D.Clin.Dent (Adelaide), MRACDS (Orth), MOrth RCS (Edin)

MEDICAL AND DENTAL HISTORY FORM

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First):*	☐ M ☐ F	**DOB:**
Title:	☐ Master ☐ Miss ☐ Mr ☐ Mrs ☐ Ms ☐ Dr	
Residential address:		
Postal address:		
Telephone number (Home):		**E-Mail:**
Telephone number (Mob):		
What is the preferred method of contact?	☐ Telephone ☐ E-mail_____	
Name of dentist:		
Name of medical practitioner:		
Health fund:		
How did you hear about us?	☐ Dentist, Dr_____ ☐ Family/Friend_____	
	☐ Yellow Pages ☐ Website ☐ Google	
What is your main reason for seeking orthodontic advice?		
Has any family member had orthodontic treatment?		

MEDICAL HISTORY		
Do you have a health problem?	☐ Yes	☐ No
Have you had any history of serious illness/accident/operations?	☐ Yes	☐ No
Are you being treated by a medical professional at the moment?	☐ Yes	☐ No
Are you currently taking any medication(s)?	☐ Yes	☐ No
Have you ever taken medication for a bone disorder (e.g. Fosamax)?	☐ Yes	☐ No
Are you smoking?	☐ Yes	☐ No
Are you pregnant or do you plan on becoming pregnant during the course of treatment?	☐ Yes	☐ No
Do you require antibiotic cover prior to any dental work?	☐ Yes	☐ No
Please list ALL known allergies (eg. Latex, peanuts, antibiotics, nickel, Codeine, Ibuprofen, local anesthetic):		
Are there any medical issues you would like to discuss with the orthodontist in private?	☐ Yes	☐ No

PLEASE TICK AND WRITE DOWN DETAILS AS APPROPRIATE				
	Past	Present	Never	Details
Allergies	☐	☐	☐	
Asthma	☐	☐	☐	
Bleeding disorders	☐	☐	☐	
Bone disorders	☐	☐	☐	
Broken bones	☐	☐	☐	
Cleft palate	☐	☐	☐	
Diabetes	☐	☐	☐	
Endocrine problems	☐	☐	☐	
Emotional problems	☐	☐	☐	
Epilepsy/Convulsions	☐	☐	☐	
Fainting/Dizziness	☐	☐	☐	
Hearing problems	☐	☐	☐	
Heart disease	☐	☐	☐	
Heart murmur	☐	☐	☐	
Hepatitis	☐	☐	☐	
HIV/AIDS	☐	☐	☐	
Kidney Problems	☐	☐	☐	
Learning disabilities	☐	☐	☐	
Liver problems	☐	☐	☐	
Pneumonia	☐	☐	☐	
Rheumatic fever	☐	☐	☐	
Speech problems	☐	☐	☐	
Tonsillitis	☐	☐	☐	
Tuberculosis	☐	☐	☐	

DENTAL HISTORY		
Have you had an orthodontic consultation previously?	☐ Yes	☐ No
Have you had any previous orthodontic treatment? (e.g. plates, space maintainers, functional appliance?)	☐ Yes	☐ No
Have you had any injury to the jaws or teeth (both baby teeth and permanent teeth)?	☐ Yes	☐ No
Have you had any injury to the face/jaws/chin?	☐ Yes	☐ No
Have you ever experienced pain of the jaws, "locking" of the jaws or "clicking of the jaws"	☐ Yes	☐ No
Date of last dental examination		

FAMILY DENTAL HISTORY		
Unusual dental problems (e.g. missing teeth, extra teeth):	☐ Yes	☐ No
Jaw size imbalance in parents/siblings?	☐ Yes	☐ No

CHIEF COMPLAINT		
What is the reason for seeing us and what is your main concern?		
Do you play any sports?	☐ Yes	☐ No
Do you play a musical instrument?	☐ Yes	☐ No

I have read and understood the above questions. If there are any changes later to this history record or medical/dental status, I will inform the practice.

Signed (Patient):_____ Date:_____

Signed (Orthodontist):_____ Date: _____