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 the patient's medical record.

Name *(Last, First):*	☐ M ☐ F	**DOB:**
Title:	☐ Master ☐ Miss ☐ Mr ☐ Mrs ☐ Ms ☐ Dr	
Occupation/school:		
Residential address:		
Postal address:		
Telephone number (Home):		**E-Mail:**
Telephone number (Mob):		
Mother's name:		**Mother's Phone Number:**
Mother's address: ☐ same as above		
Father's name:		**Father's Phone Number:**
Father's address: ☐ same as above		
Who is responsible for the account?		
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 the patient's main reason for seeking orthodontic advice?		
Has any family member had orthodontic treatment?		

MEDICAL HISTORY		
Does the patient have a health problem?	☐ Yes	☐ No
Is there a history of serious illness/accident/operations?	☐ Yes	☐ No
Is the patient being treated by a medical professional at the moment?	☐ Yes	☐ No
Is the patient currently taking any medication(s)?	☐ Yes	☐ No
Has the patient ever taken medication for a bone disorder (e.g. Fosamax)?	☐ Yes	☐ No
Is the patient smoking?	☐ Yes	☐ No
Is the patient pregnant or does the patient plan on becoming pregnant during the course of treatment?	☐ Yes	☐ No
Does the patient 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		
Has the patient had an orthodontic consultation previously?	☐ Yes	☐ No
Has the patient had any previous orthodontic treatment? (e.g. plates, space maintainers, functional appliance?)	☐ Yes	☐ No
Has the patient had any injury to the jaws or teeth (both baby teeth and permanent teeth)?	☐ Yes	☐ No
Has the patient had any injury to the face/jaws/chin?	☐ Yes	☐ No
Does the patient have a thumb-sucking habit?	☐ Yes	☐ No
Has the patient ever experienced pain of the jaws, "locking" of the jaws or "clicking of the jaws"	☐ Yes	☐ No
Date of patient's 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

PATIENT'S CHIEF COMPLAINT

What is the reason for seeing us and what is the patient's main concern?		
Does the patient play any sports?	☐ Yes	☐ No
Does the patient play a musical instrument?	☐ Yes	☐ No

Please let the orthodontist know if there are any other concerns you may have but do not wish to discuss in front of children. It is important that we are aware of any behavioural difficulties.

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 (Parent/Guardian):____ Date:_________________________

Signed (Orthodontist):____ Date: _________________________