LOCKETT ORTHODONTICS

Patient's Name: _____ Birth Date: _____ Date: _____

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, have you 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, pneumonia?
☐yes ☐no ☐dk/u Problems of the immune system?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, jaundice or liver problems?
☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problems?
☐yes ☐no ☐dk/u Mental health disturbance or depression?
☐yes ☐no ☐dk/u Vision, hearing, tasting, or speech difficulties?
☐yes ☐no ☐dk/u Loss of weight recently, poor appetite?
☐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 Tire easily?
☐yes ☐no ☐dk/u Chest pain, shortness of breath / swelling ankles?
☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arterio-sclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no ☐dk/u Skin disorder?
☐yes ☐no ☐dk/u Do you have a well-balanced 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 Hay fever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
☐yes ☐no ☐dk/u Osteoporosis?

WOMEN ONLY

☐yes ☐no ☐dk/u Are you pregnant?
☐yes ☐no ☐dk/u Are you anticipating becoming pregnant?

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 Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐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 Are you currently taking or have you ever taken any oral or intravenous bisphosphonates for serious disorders/cancers, osteoporosis, osteopenia or other uses?
If so, please name below:
Medication_____ Length of time taken _____
Medication_____ Length of time taken _____
Medication_____ Length of time taken _____

☐yes ☐no ☐dk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine?
If so, please name below:
Medication_____ Length of time taken _____
Medication_____ Length of time taken _____
Medication_____ Length of time taken _____

☐yes ☐no ☐dk/u Do you currently have or ever had a substance abuse problem?
☐yes ☐no ☐dk/u Do you chew or smoke tobacco?
☐yes ☐no ☐dk/u Operations? Describe: _____
_____
☐yes ☐no ☐dk/u Hospitalized? Describe: _____
_____
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe:_____
_____
☐yes ☐no ☐dk/u Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____
Are there any other medical conditions that we should be aware of?
_____
_____

FAMILY MEDICAL HISTORY

Do the parents or siblings have or have ever had 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

Now or in the past, have you had:

☐yes ☐no ☐dk/u Permanent or "extra" (supernumerary) teeth removed?
☐yes ☐no ☐dk/u Supernumerary (extra) or congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
☐yes ☐no ☐dk/u Teeth sensitive to hot or cold; teeth throb or ache?
☐yes ☐no ☐dk/u Jaw fractures, cysts or mouth infections?
☐yes ☐no ☐dk/u "Dead teeth" or root canals treated?
☐yes ☐no ☐dk/u Bleeding gums, bad taste or mouth odor?
☐yes ☐no ☐dk/u Periodontal "gum problems"?
☐yes ☐no ☐dk/u Food impaction between teeth?
☐yes ☐no ☐dk/u "Gum boils", frequent canker sores or cold sores?
☐yes ☐no ☐dk/u Thumb, finger, or sucking habit?
Until what age? ___
☐yes ☐no ☐dk/u Abnormal swallowing habit (tongue thrusting)?
☐yes ☐no ☐dk/u History of speech problems?
☐yes ☐no ☐dk/u Mouth breathing habit, snoring or difficulty in breathing?
☐yes ☐no ☐dk/u Tooth grinding or jaw clenching?
☐yes ☐no ☐dk/u Any pain, clicking or locking in jaw or ringing in the ears?
☐yes ☐no ☐dk/u Any pain or soreness in the muscles of the face or around the ears?
☐yes ☐no ☐dk/u Difficulty in chewing or jaw opening?
☐yes ☐no ☐dk/u Aware of loose, broken or missing restoration (fillings)?
☐yes ☐no ☐dk/u Any teeth irritating cheek, lip, tongue or palate?
☐yes ☐no ☐dk/u Concerned about spaced, crooked or protruding teeth?
☐yes ☐no ☐dk/u Aware or concerned about under or over developed jaw?
☐yes ☐no ☐dk/u Any relative with similar tooth or jaw relationships?
☐yes ☐no ☐dk/u Any wisdom tooth problems?
☐yes ☐no ☐dk/u Had periodontal (gum) treatment?
☐yes ☐no ☐dk/u Any serious trouble associated with any previous dental treatment?
☐yes ☐no ☐dk/u Been under another dentist's care?
Specialist _____
Other _____
☐yes ☐no ☐dk/u Ever had a prior orthodontic examination or treatment?
☐yes ☐no ☐dk/u Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often does you brush: _____ floss: _____

What is your primary concern? Why are you here? _____

_____

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: _____
(Patient)

Signed: _____ Date Signed: _____
(Orthodontist)