Pacificwest Dental Group New Patient Medical History Form

Medical History

Name_____ Date of Birth _____

Address_____ Phone_____

Physician (if you have one)_____ Date of Last Visit_____

Please circle Yes or No (If YES, please fill in details)

Yes No Is the patient taking any medication? _____

Yes No Is the patient allergic to any medication?_____

Yes No History of a major illness? _____

Yes No Has the patient had any operations?_____

Yes No Ever been involved in a serious accident?_____

Yes No Have you seen a physician in the last 12 months? Why?_____

Female Patients Only:

Yes No Has menstruation started?_____

Yes No Is the patient pregnant?_____

Please circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problem	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorder	HIV/AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

_____

DENTAL HISTORY

Family Dentist_____ Date of Last Visit_____

What concerns you most about your teeth?_____

Yes No Is the patient **presently in any dental pain**? _____

Yes No Ever experienced any **unfavorable reaction to dentistry**? _____

Yes No Has the patient ever **lost or chipped any teeth**? _____

Yes No Is any part of your mouth **sensitive to temperature**? Where?_____

Yes No Is any part of your mouth **sensitive to pressure**? Where?_____

Yes No Do your **gums bleed** when brushing? _____

Pacificwest Dental Group New Patient Medical History Form

What is the patient's attitude toward receiving orthodontic treatment?_____

Yes No Has the patient **ever seen an orthodontist**? If yes, Who and When? _____

Yes No Has **anyone in the family received orthodontic treatment**? _____

If yes, how did they feel about the result?_____

Yes No Does patient **need extra help with instructions**? _____

Yes No Is the patient **sensitive or self-conscious about his/her teeth**?_____

Yes No Are you aware that some appointments will be during school hours? _____

Yes No Have there been any **injuries to face, mouth, or teeth**? _____

Yes No Do **teeth or jaws ever feel uncomfortable** first thing in the morning? _____

Yes No Experience **jaw clicking or popping**? _____

Yes No Aware of **clenching or grinding teeth** during the day?_____

Yes No Experience **"tension" headaches**? _____

Yes No Has the patient ever experienced **chronic ringing in the ears**? _____

Yes No Any type of **thumb or tongue habit**?

Yes No Do you **Snore** loudly?

Yes No Has someone **observed you stop breathing during your sleep**?

Yes No Is your **BMI higher than 35kg/m^2**

Yes No Is your **neck circumference more than 16"**

Yes No Is the patient a **mouth breather**?

Yes No Do you often **feel tired, fatigued, or sleepy during the daytime**?

Yes No Do you have or are you being treated for **high blood pressure?**

Yes No Are you **older than 50 years old**

Score: 0-2 Low Risk 3-4 Intermediate 5-8 High Risk

BENEFITS

Benefits of Orthodontics: Aesthetic, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I have authorized Dr. Wang/Dr.LEE to perform a complete orthodontic evaluation.

Signature:_____ Date _____