Orthodontic Health History

Nanton Dental CARE

Patient name:_____

Present Health Status: Good Fair Poor Under Treatment (specify)_____

Medications: _____

Does the patient:

Have allergies to: Seasonal Grasses___ Food _____
Drugs_____ Other _____

Snore when sleeping? Yes No

Breathe through mouth? Seldom Sometimes Usually

Comments?_____

Have frequent colds? Yes No

Have frequent sore throat or tonsillitis? Yes No

Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from Allergist, or Ear, Nose, Throat Specialist (ENT)?

Yes No If Yes: When_____ Whom_____

Tonsils/Adenoids removed_____

Nasal Sprays_____Tubes in ears_____

Does the patient have pain or clicking in jaw joints? Yes No

Has there been injury to the face, jaws, or teeth? Yes No

Has speech correction been suggested or received? Yes No

Has the patient experienced any of the following:

Thumb/Finger sucking Yes No Until what age?_____

Lip biting/sucking? Yes No Until what age?_____

Grinding of teeth? Yes No Until what age?_____

Tongue thrusting? Yes No Until what age?_____

Other habits Yes No Until what age?_____

Has the patient had unusual dental experiences? Yes No

Specify_____

Have you had any other orthodontic consultation or treatment Yes No

When_____ Whom_____

Has anyone in the immediate family ever received Orthodontic treatment? Yes No

What is the specific patients interest in Orthodontic treatment (besides your own)

Patients wants treatment Unwilling but here Uncooperative

What in your opinion is the primary problem or concern?

_____

What are your expectations from the treatment?

_____

Any Additional comments:

_____

_____

_____

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