HUDSON ORTHODONTICS

"A smile to last a lifetime."

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HEALTH HISTORY

Confidential

Patient Name: _____ Birthdate: _____/_____/_____
First Last MI

DENTAL HISTORY

Have you ever visited an orthodontist before? Y / N
Have we treated other family members before? Y / N
Check (✔) if you have had problems with any of the following:

- ☐ Jaw joint pain/discomfort (TMD/TMJ
- ☐ Clenching/grinding teeth
- ☐ Lip sucking/biting
- ☐ Mouth breathing
- ☐ Nail biting
- ☐ Thumb/ finger sucking
- ☐ Chewing/eating problem
- ☐ Bleeding Gums
- ☐ Periodontal treatment
- ☐ Speech
- ☐ Sensitivity to hot/cold
- ☐ Sensitivity to sweets

Do you know of any missing or extra permanent teeth? _____
Have you ever had injury to: Teeth? _____ Mouth? _____ Chin? _____
Check (✔) if you wish to change any of the following about your teeth/facial appearance:

- ☐ Wouldn't change anything
- ☐ Straighten front teeth
- ☐ Straighten back teeth
- ☐ Upper teeth too far forward
- ☐ Upper teeth too far backward
- ☐ Upper teeth too long
- ☐ Upper teeth too short
- ☐ Lower teeth too far forward
- ☐ Lower teeth too far backward
- ☐ Other
- ☐ Wouldn't change anything
- ☐ Show more teeth or gum
- ☐ Show less teeth or gum
- ☐ Move chin more forward
- ☐ Move chin more backward
- ☐ Move chin more left
- ☐ Move chin more right
- ☐ Move upper lip forward
- ☐ Move upper lip backward
- ☐ Make it easier to close lips

MEDICAL HISTORY

Are you currently being treated by a physician? Y / N Physician's Name: _____
If yes, Reason: _____ Last visit: _____/_____/_____ Phone: (_____)_____-_____
Has puberty or menstruation begun? Y / N
(Women) Are you pregnant? Y / N
Check (✔) if you have any history of the following:

- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Tuberculosis
- ☐ Kidney/Liver Ailments
- ☐ Mitral Valve Prolapse
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Recent Joint Replacement
- ☐ Hepatitis
- ☐ Smoking
- ☐ Other: _____

Are any Antibiotic Pre-Medications required for any dental procedures? Y / N

MEDICATIONS

Are you taking any over-the-counter medications? Y / N
If yes, please list: _____
Are you taking any prescription medications? Y / N
If yes, please list: _____

ALLERGIES

Check (✔) if you have any allergies/sensitivities to:

- ☐ Latex
- ☐ Metal
- ☐ Medications
  Please list: _____
- ☐ Other: _____

SIGNATURE

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. VIRGINIA LAW requires us to inform you that your blood may be tested for HIV (AIDS) virus if any healthcare worker is accidently exposed to your blood in a manner that could transmit HIV infection. Your consent is NOT requires, but you will be informed if tested.

Signature (Parent/Guardian if patient is a minor): _____ Date: _____/_____/_____