SCRIPPS POWAY ORTHODONTICS
CHRISTOPHER MAULIK, DMD, MDS

YOUTH MEDICAL DENTAL HISTORY FORM

Date: _____

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: Male ☐ Female ☐ Prefers To Be Called _____

Custodial Parent'(s) or Guardian'(s) Name: Mother: _____ Father: _____

Patient's Address: _____

City: _____ State/Province: _____ Postal Code: _____ Home Phone No.: (____) _____-_____

Patient's E-mail Address: _____ Cell phone/pager: (_____) _____-_____

Parent's E-mail Address: _____ Cell phone/pager: (_____) _____-_____

Attends School At: _____ Grade: _____ Musical Instruments Played: _____

Sports And/Or Hobbies: _____

No. of brothers and sisters: _____ Ages: _____ Other family members treated here: _____

Patient's Present Weight _____lbs. Patients Present Height _____ft. _____in.

Additional Address of Parent/Guardian: _____

Additional E-mail Address: _____ Cell phone/pager: (_____) _____-_____

Preferred method to be notified of future visits: Text ☐ Email ☐ Preferred method to receive general correspondence: Mail ☐ Email ☐

Name of Dentist: _____ Date Last Seen: _____ Reason: _____

Name Of Physician (s): _____ Date Last Seen: _____ Reason: _____

Who Is Financially Responsible For This Account? Last Name: _____ First Name: _____ MI: _____

Address (if different from patient's): _____ Years at address: _____

If less than five years, previous address: _____

Phone No. (if different than patient's): (_____) _____-_____ S.S.N/S.I.N .: _____

Employer: _____ How many years? _____

Insurance Coverage For Dental Treatment? Yes ☐ No ☐ Insurance Coverage For Orthodontic Treatment? Yes ☐ No ☐

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____ Birth Date: _____

Employed By: _____ Dental Insurance Company: _____ Group No. _____

Medical Insurance Company: _____ Group No. _____

PRIMARY CONCERN

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

_____

Who suggested that you might need orthodontic treatment? _____

Why did you select our office? _____

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, has the patient 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 or chemotherapy?
☐yes ☐no ☐dk/u Stomach ulcer or hyperacidity?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis or 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 problem?
☐yes ☐no ☐dk/u Fainting spells, seizures, epilepsy or neurological problem?
☐yes ☐no ☐dk/u Mental health disturbance or behavioral problem?
☐yes ☐no ☐dk/u Vision, hearing, tasting or speech difficulties?
☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?

☐yes ☐no ☐dk/u Cardiovascular problem (heart trouble, heart attack, inborn heart defects, heart murmur or rheumatic heart disease)?
☐yes ☐no ☐dk/u Skin disorder?
☐yes ☐no ☐dk/u Frequent headaches?
☐yes ☐no ☐dk/u Eye, ear, nose or throat condition?
☐yes ☐no ☐dk/u Hayfever, asthma, sinus trouble or hives?
☐yes ☐no ☐dk/u Tonsil or adenoid conditions?
☐yes ☐no ☐dk/u Operations? Describe: _____
☐yes ☐no ☐dk/u Hospitalized? For: _____
☐yes ☐no ☐dk/u Other physical problems or symptoms?
Describe: _____
☐yes ☐no ☐dk/ u Being treated by another health care professional?
For: _____

Are there any other medical conditions that we should be aware of?

_____

GIRLS ONLY

☐yes ☐no ☐dk/u Has the patient started her monthly periods?
If so, approximately when? _____
☐yes ☐no ☐dk/u Is the patient pregnant?

PATIENT PROFILE

☐yes ☐no ☐dk/u Is the patient fearful of the dentist?
☐yes ☐no ☐dk/u Is she/he self-conscious about their teeth?
☐yes ☐no ☐dk/u Is she/he taking medication, or non prescription medicine? Please name them.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Allergies or reactions to any of the following:

☐yes ☐no ☐dk/u Local anesthetics (Novocaine or Lidocaine)
☐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 Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Other substances (specify) _____

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DENTAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** ☐**dk/u** Primary (baby) teeth removed that were not loose?

☐**yes** ☐**no** ☐**dk/u** Permanent or "extra" 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** 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, snoring or difficulty in breathing?

☐**yes** ☐**no** ☐**dk/u** Tooth grinding, jaw clenching clicking or locking?

☐**yes** ☐**no** ☐**dk/ u** Any pain 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 encountered in chewing or jaw opening?

☐**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** "Gum Boils", frequent canker sores or cold sores?

☐**yes** ☐**no** ☐**dk/u** Taking any forms of fluoride?

☐**yes** ☐**no** ☐**dk/u** Any relative with similar tooth or jaw relationships?

☐**yes** ☐**no** ☐**dk/u** Had periodontal (gum) treatment?

☐**yes** ☐**no** ☐**dk/u** Would patient object to wearing orthodontic appliances (braces) should they be indicated?

☐**yes** ☐**no** ☐**dk/u** Any serious trouble associated with any previous dental treatment?

☐**yes** ☐**no** ☐**dk/u** Ever had a prior orthodontic examination or treatment?

☐**yes** ☐**no** ☐**dk/u** Been under another dentist's care?
Specialist _____
Other _____

How often does the patient brush? _____ Floss? _____

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: _____
(Parent or Guardian)

Signed: _____ Date Signed: _____
(Dental Staff Member)

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