BUCHANAN | CHUN ORTHODONTICS

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Orthodontic Specialists

Welcome! *We are pleased to welcome you to our orthodontic practice. Please complete the following medical history form as completely as you can before your visit. If you have any questions, just ask. We will be glad to help. We look forward to working with you in achieving your goal... A great smile!*

Patient Information

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Medical History

Check yes or no to the following questions: for office use only: Initials _____ Date _____

Now or in the past have you ever had or been treated for:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	❑	❑	Cerebral Palsy	❑	❑	Tonsils and Adenoids removed	❑	❑
Prolonged Bleeding	❑	❑	ENT Disorder	❑	❑	Respiratory Diseases	❑	❑
Heart Trouble	❑	❑	Bone Disorders	❑	❑	Fainting and Dizziness	❑	❑
Epilepsy	❑	❑	Asthma	❑	❑	Jaw Joint noises, Pain or Clicking	❑	❑
Diabetes	❑	❑	Infectious Diseases	❑	❑	Hepatitis A, B, C, D, E, G (circle)	❑	❑
Endocrine Problems	❑	❑	Tuberculosis	❑	❑	Pneumonia	❑	❑
Mononucleosis	❑	❑	AIDS	❑	❑	HIV positive	❑	❑
Thyroid Problems	❑	❑	High Blood Pressure	❑	❑	Eating Disorder - Anorexia, Bulimia	❑	❑
Heart Murmur/defect	❑	❑	Skin Disorder	❑	❑	Migraine Headaches	❑	❑
Osteoporosis	❑	❑	Arthritis	❑	❑	Mental health disturbance, depression	❑	❑
Auto Immune Disorder	❑	❑	Medical/	❑	❑	Cancer, Tumor, Radiation,	❑	❑
Glaucoma	❑	❑	Genetic Syndrome			Chemotherapy		

Explain: _____

_____

Allergies: Are you allergic to...

	Yes	No		Yes	No		Yes	No
Aspirin	❑	❑	Ibuprofen, Motrin, Advil	❑	❑	Pollen, grass	❑	❑
Penicillin	❑	❑	Other Antibiotics	❑	❑	Sulfa Drugs	❑	❑
Metals (jewelry)	❑	❑	Latex (gloves, balloons)	❑	❑	Vinyl	❑	❑
Acrylic	❑	❑	Nickel Products	❑	❑	Animals	❑	❑

Explain: _____

Medications: Please name any medications you are currently taking.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

	Yes	No
Has the patient ever taken Bisphosphonate medications for osteoporosis?	❑	❑
Has the patient ever taken Phen-Phen medication?	❑	❑
Is the patient under the care of a physician for a specific condition? (explain below)	❑	❑
Does the patient have a substance abuse condition? (explain below)	❑	❑
Any change in the medical status in the past year? (Accident, Injury or Surgery) (explain below)	❑	❑
Does the patient smoke or chew tobacco?	❑	❑
Hospitalizations (explain below)	❑	❑
Operations (explain below)	❑	❑
Chiropractic Care?	❑	❑

Describe: _____

_____

_____

Family Medical History

Is there a family history of?

	Yes	No		Yes	No
Bleeding Disorders	❑	❑	Diabetes	❑	❑
Arthritis	❑	❑	Severe Allergies	❑	❑
Unusual Dental Problems	❑	❑	Jaw Size Imbalance	❑	❑
Medical/ Genetic Syndrome	❑	❑			

Other: _____

Describe: _____

Dental History

Current Dentists Name: _____

Address (City, State, Zip): _____

Previous Orthodontists? Name: _____

Address (City, State, Zip): _____

Previous Orthodontic Treatment (describe): _____

	Yes	No
Has the patient ever sucked thumb or finger? Until what age? Age: _____	❑	❑
Does the patient have any speech difficulties? Any speech therapy? Tongue Thrust?	❑	❑
Have the teeth or jawbones been injured due to accident or falls? (describe below)	❑	❑
Have you been informed of any missing permanent teeth?	❑	❑
Have you been informed of any impacted teeth?	❑	❑
Is the patient apprehensive about wearing braces?	❑	❑
Does the patient play any musical instruments with the mouth? Type: _____	❑	❑
Are you under the care of another dental specialist? (explain below)	❑	❑
The date of your last dental visit Date: _____		
Was all the required dental work completed at your last dental appointment? (explain below)	❑	❑

Explain: _____

_____

_____

Chief Concerns:
Briefly state the major orthodontic concerns that you would like us to address:

_____

_____

Does your dentist have any concerns or restorative plans for your teeth we should know about?

_____

_____

Now or in the past have you ever had?

	Yes	No		Yes	No		Yes	No
Extra Teeth	❑	❑	Missing Teeth	❑	❑	Teeth sensitive to hot / cold	❑	❑
Cysts	❑	❑	Mouth Infections	❑	❑	Periodontal (gum Disease)	❑	❑
Root Canals	❑	❑	Jaw Fractures	❑	❑	Canker Sores, Cold Sores	❑	❑
Difficulty in Breathing, Snoring	❑	❑	Tooth Grinding / Clenching	❑	❑	Jaw Pain / TMJ	❑	❑
Cracked Teeth	❑	❑	Sore Jaw Muscles	❑	❑	Wisdom Teeth Problems	❑	❑
Clicking or Popping of the Jaws	❑	❑	Jaw Surgery	❑	❑	Locking of Jaw	❑	❑
Cleft Lip or Palate	❑	❑	Dental Implants	❑	❑	Tongue Thrust	❑	❑

Explain: _____

_____

I have read and understand the above questions. If there are any changes later to this record or medical/dental status, I will so inform this practice.

Signed: _____ **Date Signed:** _____
(Patient or Parent or Guardian)

Women Only

	Yes	No
Are you pregnant now or are planning to become pregnant?	❑	❑
Girls: Has the patient started monthly periods? (Puberty has started)	❑	❑

Approximately when? _____

Medical History Updates or Changes

Comments:

_____

_____

Signed: _____ Date Signed: _____
(Patient or Parent or Guardian)

Staff: _____ Date Signed: _____